A Publication of Westchester Public Private Partnership for Aging Services

Elder Law

Q&A:

An Introduction to Aging Issues an Planning for the Future

21st Edition

Written by members of the

SENIOR LAW DAY
COLLABORATIVE

STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL

Letitia James
Attorney General

Executive Office

Dear Friends:

It is my pleasure to once again introduce ***Elder Law Q&A: An Introduction to Aging Issues and Planning for the Future***. I want to commend the Harry and Jeanette Weinberg Center at the Hebrew Home at Riverdale, the Westchester Public Private Partnership for Aging Services, and the Pace Women's Justice Center for producing the 21st edition of this outstanding resource. I am proud to partner with these exceptional organizations in the fight for Elder Justice.

During these unprecedented times, New York's senior population has played a crucial role in meeting the array of challenges facing us all. They have been steadfast allies in the ongoing fight to stem the COVID-19 pandemic and recover from its aftermath. They are also making tremendous contributions to the movement to improve our criminal justice system and build a more equitable future. By sharing their life-experience, enriching our sense of history, and inspiring others through their creativity, resilience, and endurance; they strengthen us all and move New York toward a brighter future.

Sadly, the current troubles have given rise to a new host of scams and fraudulent activities, many specifically targeting seniors. Several members of our aging population are also contending with new financial hardships and health challenges. That is why events like this year's Virtual Senior Law Day and publication's like ***Elder Law Q&A*** are more needed than ever. By providing up-to-date, easy to understand information, these resources empower New Yorkers to protect themselves from fraud and abuse. Whether you are a senior yourself, or you are a caregiver, ally, activist, advocate, or family member – I have no doubt that the advice contained within will be useful. ***Elder Law Q&A*** offers tips and instructions to help you get started planning in advance for long and short term healthcare needs, as well guidance for making future financial decisions. While not a substitute for legal advice from a qualified attorney, this guide provides basic information about health directives, powers of attorney, trusts, taxes, wills, insurance, and Medicare

and Medicaid. Additionally this booklet shines a light on the many forms of elder abuse, including: physical abuse, psychological, and emotional abuse, sexual abuse, financial exploitation, and neglect. You will also find resources for reporting abuse and obtaining help for victims.

Please remember that the Attorney General's Office is here to help as well. Our Consumer Frauds and Protection Bureau accepts complaints about suspected scams and unscrupulous businesses, our Medicaid Fraud Control Unit investigates reports of suspected nursing home abuse or neglect, and our Smart Seniors outreach initiative provides speakers and publications on wide range of issues affecting seniors. You can visit my website at ag.ny.gov/smart-seniors for more information.

We are also extremely grateful to Steven A. Schurkman, Esq. of Keane & Beane, P.C. for his expertise in the elder law field, and for writing and annually editing the Elder Law Q & A. Our deep appreciation also goes to Deepankar Mukerji, Esq., Frances M. Pantaleo, Esq., Sarah A. Steckler, Esq., Jeffrey A. Cohen, Esq., Mary Beth Morrissey, Ph.D., MPH, J.D., David Leven, J.D., and The Honorable Judith J. Gische (Associate Justice, Appellate Division First Department of New York State Supreme Court) for their careful reading and considered comments in developing this publication. The online link for this publication is:

https://www.seniorlawday.info/resources/

Again, I applaud the Westchester Public Private Partnership for Aging Services, the Harry and Jeanette Weinberg Center for Elder Justice at the Hebrew Home at Riverdale, and the Pace Women's Justice Center for their hard work in creating this informative guide. I am sure it will be put to good use.

Sincerely,

Letitia James
New York State Attorney General

ABOUT THE PRIMARY AUTHOR

Steven A. Schurkman has more than 35 years experience in the practice of law, focusing in the areas of estate planning, probate, elder law, real estate and commercial transactions. Since joining Keane & Beane, P.C., Mr. Schurkman has greatly expanded the trusts and estates department and developed its elder law practice. He advises individuals and families concerning estate tax, asset preservation and business succession planning. He also counsels individuals with disabilities and assists families with the establishment of supplemental needs trusts and guardianships. He also advises clients concerning the use of long term care insurance and reverse mortgages as well as on issues relating to hospital discharge, medical coverage, admission to skilled nursing facilities and Medicare and Medicaid home care services.

Mr. Schurkman has received numerous awards and recognition over the years, including Elder Justice Distinguished Achievement Award from the Pace Women's Justice Center (2013), the Above the Bar Award for Most Socially Conscious Attorney awarded by Westchester County Business Journal, Pace University School of Law and Westchester County Bar Association (2009), and the Humanitarian Award from the Westchester Public Private Partnership for Aging Services (2009). He also enjoys tennis, skiing, spending time with family, and rooting for the Orioles.

This printing was made possible by a generous grant from the Westchester Public Private Partnership for Aging Services and the Harry and Jeanette Weinberg Foundation. This project was initially sponsored by a grant administered by the New York State Division of Criminal Justice Services. Prior support has been provided by the following: U.S. Department of Health and Human Services, New York State Department of Aging, and Westchester County Department of Senior Programs and Services. Points of view in this document are those of the authors and do not necessarily represent the official position or policies of these agencies.

©2000 New York State Division of Criminal Justice Services and the Pace Women's Justice Center

OFFICE OF THE DISTRICT ATTORNEY
WESTCHESTER COUNTY
WESTCHESTER COUNTY COURTHOUSE
111 Dr. Martin Luther King, Jr. Blvd.
White Plains, New York 10601
(914) 995-3414

ANTHONY A. SCARPINO, JR.
DISTRICT ATTORNEY

Dear Friends:

The Westchester County District Attorney's Office is so pleased to be a part of the latest edition of Elder Law Q & A: An Introduction to Aging Issues and Planning for the Future and to be a part of the vibrant work being done every day in Westchester to support our elderly population.

At the Westchester County District Attorney's Office, we have several initiatives designed to address the issues seniors face every day regarding safety and the criminal justice system. Our Elder Abuse Unit prosecutes all kinds of diverse cases of elder abuse, including cases of domestic violence, fraud, larceny and physical abuse. Prosecutors and Investigators dedicated to work in these areas take great care to work sensitively with elderly victims of crime and to seek justice in the Courts. Moreover, in addition to our prosecution duties, our Elder Abuse Unit is always active, training police throughout the county as well as other organizations who work with seniors, to teach them how to identify and investigate cases of elder abuse. Our Elder Abuse Unit staff also regularly visit seniors and senior groups throughout Westchester to talk about safety and safety measures such as skills to avoid scams that target older residents, and all designed to provide information to help keep our vulnerable seniors from falling victim to crime.

Our office also operates a phone- in reporting line available 24/7, where callers can leave information for the Elder Abuse Unit Team with questions or concerns regarding abuse taking place in the community. Callers can even call anonymously and all calls are returned promptly!

The Westchester County District Attorney's Office is also proud of our successful collaboration with many of our partners in the community on the Westchester Elder Abuse Multi-Disciplinary Team. There, professionals from many agencies including the Westchester County District Attorney's Office, gather monthly to review challenging cases of elder abuse and collectively seek solutions related to a range of issues including safety, financial and health concerns, civil and criminal legal issues and any other matter brought to the team's attention concerning the wellbeing of an elderly Westchester resident.

This publication, and Senior Law Day events are great ways for seniors to receive information about an entire variety of topics, including the criminal justice system. Our office always stands ready to assist you if you need us. Our Elder Abuse Unit can be reached at 914-995-3000 and our 24 hour reporting line is 914-995-1940.

On behalf of the Westchester County District Attorney's Office, thank you to the Senior Law Day Collaborative for organizing our Senior Law Day events and for creating this important resource for our community. And thanks to all of the organizations with whom we collaborate to make Westchester safe for seniors and so quick to respond when the criminal justice system is involved.

Very Truly Yours

ANTHONY A. SCARPINO
DISTRICT ATTORNEY

Fredric I. Green
Second Deputy District Attorney
Chief, Special Prosecutions Division

TABLE OF CONTENTS

CLICK ON THE PAGE NUMBER TO JUMP TO THAT SECTION

Elder Law and Elder Lawyers – The Basics 2

Health Care Planning 4

Future Care Planning – Managing Finances and Assets 13

- Powers of Attorney 13
- Living or Inter Vivos Trusts 20
- Wills 24

Taxes 26

- Estate & Gift Taxes 26
- Secure Act for Retirement Planning 33

Medicare 40

Long Term Care Insurance 44

Preservation of Assets/Medicaid Planning 48

Supplemental Security Income (SSI) vs. Social Security Disability Insurance (SSDI) 68

Elder Abuse 73

Mental Health Services for Older Adults 82

Westchester Public/Private Partnership for Aging Services 87

Health Care Proxy (Appendix A) 91

New York Living Will (Appendix B) 101

MOLST – Medical Orders for Life-Sustaining Treatment (Appendix C) 104

Do Not Resuscitate (Appendix D) 140

Power of Attorney – New York Statutory Short Form (Appendix E) 143

How to Get Medicaid Despite Having Excess Income (Appendix F) 156

Managed Long-Term Care (MLTC) Plans Serving New York State (Appendix G) 171

Documents Required for Medicaid Application (Appendix H) 176

Access New York Health Care Medicaid Application
(With NYC and non-NYC supplements) (Appendix I) 179

Senior Law Day Sponsorship Form 209

ELDER LAW AND ELDER LAWYERS - THE BASICS

What is elder law?

The phrase elder law encompasses a wide range of legal topics and is used generally to refer to all legal matters that affect seniors and their families. Of course, many of the legal issues that are faced by the aging population are also confronted by others in the general population, including, in particular, people with disabilities.

What is an elder law attorney?

An elder law attorney is a lawyer who concentrates his or her practice in legal matters pertaining to aging issues. Elder law attorneys are skilled in addressing a wide range of needs of seniors and their families. They can assist with estate planning, locating programs to address the needs of the aging community, and helping their clients obtain the care and help they need now and in the future. Among the issues an elder law attorney might be called upon to address are:

- Financial and health care planning
- Estate and tax planning
- Transfer of assets and asset preservation and protection
- Medicare and Medicaid planning
- Issues affecting older workers
- Hospital discharge and nursing homes admission issues
- Housing alternatives for seniors
- Surrogate decision making, including guardianships

I would like some advice on estate and financial planning. How do I find an elder law attorney?

As is often the case with hiring professionals, obtaining recommendations from friends, relatives, business associates, and others who are likely to have had regular contact with lawyers is a good place to start. The National Academy of Elder Law Attorneys, based in Vienna, Virginia, is a national organization of elder law attorneys which can make referrals of attorneys with elder law expertise located in your geographic area. On a local level, the Westchester County Department of Senior Programs and Services (formerly the Westchester County Office for the Aging), the Pace Women's Justice Center, the Westchester County Bar Association, other local bar associations and legal not-for-profit groups may be able to assist in providing information concerning elder law issues and/or offer lawyer referral services, which are useful resources for locating experienced counsel. The Westchester County Library System may also be a useful resource to obtain information concerning the selection of an elder law attorney. Often, such services will provide several names from a panel of attorneys known to have expertise in elder law.

It is best to interview more than one lawyer before making a choice. During the initial interview, you should request that the prospective lawyer address the issues that you believe are most important. Make sure that your lawyer is experienced in the area of elder law. To determine the lawyer's expertise, it is acceptable and proper to ask the attorney how many elder law matters the attorney handles annually, and/or what percentage of his or her practice is devoted to elder law. Inquiring as to the attorney's involvement in civic or professional groups that focus on elder law issues may also be useful in determining the attorney's expertise and level of commitment to elder law practice.

HEALTH CARE PLANNING

Health Care Proxies and Living Wills

I am healthy now, but want to make sure that if I ever become severely incapacitated, no artificial life-sustaining treatments will be imposed. How can I ensure that my wishes will be carried out?

There are three (3) documents which you should consider signing to make sure your health care wishes are followed.

1. A **health care proxy** is a legal document that can be used to protect your health care wishes in the event of your incapacity. A health care proxy allows you (the principal) to appoint someone else (the health care agent) to make health care decisions for you if you become incompetent. A successor health care agent, to act if the primary agent cannot act, may also be appointed. Routine decisions and decisions regarding life-sustaining treatment may be made using a health care proxy, but your health care agent will not be able to withhold artificial nutrition or hydration unless your intention to do so has been clearly expressed in the health care proxy itself, or in more detail in a separate living will or medical order for life-sustaining treatment. In addition, pursuant to legislation passed on October 4, 2000, you can now also state your wishes concerning organ donorship in your health care proxy. **A copy of the health care proxy form is included as Appendix A in this booklet.**

2. A **living will** is a document that sets forth your intentions concerning health care, particularly with respect to artificial life-sustaining procedures. In a living will, you can set forth your intention to forgo certain life-sustaining measures, such as artificial nutrition or hydration (which may be imposed if you are unable to eat or drink on your own) or mechanical respiration (which may be imposed if you cannot breathe on your own). Other types of treatments that you may decide to forgo include, but are not limited to, cardiopulmonary resuscitation (if your heart stops beating), antibiotic treatment, saline injections (to prevent dehydration), and pain relief (beyond a stated maximum amount). The living will sets forth your intentions concerning these important issues in the event that you, at some future point, become unable to make these decisions for yourself. **A copy of a living will form is included as Appendix B in this booklet.**

3. **A Medical Order for Life-Sustaining Treatment ("MOLST")** is an alternative form to a living will in that it allows individuals, working together with their physicians, to document their end-of-life care preferences and to assure that those preferences are made known to health care providers across the health care delivery system. The MOLST document is a physician order form (DOH-5003) on bright pink paper approved by the New York State Department of Health to be used statewide by health care providers and facilities. The MOLST form can be used to issue any orders for life-sustaining treatment for general hospital inpatients and nursing home residents. In the community, the form can be used to issue a non-hospital Do Not Resuscitate (DNR) or Do Not Intubate (DNI) order, and in certain circumstances, orders concerning other life-sustaining treatment. A copy of a MOLST form with supporting checklists is included as Appendix C in this booklet.

When should I create a health care proxy?

Every person eighteen (18) years and older should have a health care proxy.

When should I create a Living Will?

A Living Will should be created if you do not want to be kept alive artificially by medical devices if you were to be in a persistent vegetative state.

When should I ask my doctor for a MOLST?

Consider completing a MOLST with your physician if you reside in a long term care facility, reside in the community and need long term care services such as home health aides, have a serious illness, have a limited life expectancy, or if you want to avoid or receive all or some life sustaining treatment.

What do the medical terms on the MOLST form mean?

- CPR is cardiopulmonary resuscitation, a combination of techniques, including chest compressions and rescue breathing designed to pump the heart to get blood circulating and deliver oxygen to the brain until definitive treatment can stimulate the heart to start working again.
- Cardiac arrest is a condition when the heart stops beating.
- Intubation is the insertion of a tube into the windpipe to breath for you when you cannot.
- Mechanical ventilation is a machine that delivers oxygen and eliminates carbon dioxide from the body.
- Feeding tubes are inserted into the body through the nose or in the abdomen. Antibiotics are for the treatment of bacterial infections.

What are the differences and similarities between the standard one-page non-hospital DNR order and the MOLST form?

Both the Non-hospital Order Not to Resuscitate form DOH-3474 and the MOLST form (DOH-5003) are New York State Department of Health forms. Both forms are intended for individuals living at home, but the MOLST can also be used in a health care setting. The MOLST is an alternative form for patients to document their end-of-life care preferences and to assure that those preferences are made known to health care providers across the health care delivery system.

The MOLST form DOH-5003 is a bright pink multi-page form; however, a photocopy or facsimile of the original form is acceptable and legal. A Non-hospital Order Not to Resuscitate form DOH-3474 is a single page form on white paper with black ink and available in both English and Spanish. Please see Appendix D.

MOLST provides for end-of-life orders concerning resuscitation and intubation for emergency medical technicians (EMT) when the patient is in full cardio-pulmonary arrest or has pulmonary failure without acute cardiopulmonary arrest. The Non-hospital Order Not to Resuscitate form only applies to patients in full cardio or pulmonary arrest. Both forms, the MOLST form and the Non-hospital Order Not to Resuscitate form must be completed by a physician.

Unlike the Nonhospital Order Not to Resuscitate form, there are multiple patient orders contained on the MOLST form that are intended for other health care providers to follow in other health care settings such as the hospital or nursing home. The MOLST form gives prehospital care providers and agencies direction regarding the patient's end-of-life treatment orders while the Nonhospital Order Not to Resuscitate only contains a single direction regarding resuscitation. If an individual does not have either form and 911 is called, the individual will be resuscitated and care will be provided.

What do I do if the patient has both a nonhospital DNR order and a MOLST form? Which do I honor?

If the forms have different orders, you should follow the form that has the most recently dated authorization. In all instances you should follow the DNI instructions on the MOLST form if the form is signed by a physician, as the nonhospital DNR order does not provide this advice.

Does the MOLST law allow Emergency Medical Services (EMS) to honor other advance directives?

The MOLST law does not expand the ability of EMS personnel to honor advance directives such as a Health Care Proxy or Living Will. Without a do no resuscitate order from a physician, EMS must resuscitate a patient when responding to an emergency even in the patient has a health care proxy and/or living will as they are not medical orders.

What procedures are, and are not, performed if the patient presents a DNR?

Do not resuscitate ("DNR") means, for the patient in cardiac or respiratory arrest (i.e., when the patient has no pulse and/or is not breathing), No chest compressions, ventilation, defibrillation, endotracheal intubation, or medications. If the patient is not in cardiac or respiratory arrest, full treatment for all injuries, pain, difficult or insufficient breathing, hemorrhage and/or other medical conditions must be provided, unless different instructions are provided on a MOLST form by the physician documenting the patient's wishes. Relief of choking caused by a foreign object will be provided, however if breathing has stopped, ventilation will not be assisted. CPR must be initiated if no Out of Hospital, MOLST or facility DNR is presented. If a DNR order is presented after CPR has been started, CPR can then be stopped.

At what point does a health care proxy, living will or MOLST form become effective?

A health care proxy becomes effective when your attending physician determines, to a reasonable degree of medical certainty, that you, as the principal, lack capacity to make your own health care decisions. If a decision to withhold life-sustaining treatment is involved, the attending physician must consult with a second physician to confirm that you lack capacity.

If you are using a living will to decide in advance that certain life-sustaining treatments should not be used, you should also decide when and how a determination should be made that you are in a condition in which artificial life-sustaining methods should be withheld. For example, your living will might provide that artificial life-sustaining methods should be withheld if your attending physician determines that you have suffered a substantial and irreversible loss of mental or physical capacity, and that there is no reasonable expectation of recovery. Other standards can be specified as well.

If using a MOLST document instead of a living will, its effectiveness will be immediate in that a MOLST document has the strength and benefit of having your end-of-life preferences being contained in an enforceable physician's order.

Who can I appoint as my health care agent?

You can appoint almost any adult to serve as your health care agent. Often, health care agents are the spouse, children, brothers, sisters, or other relatives or close friends of the principal. It is important to choose someone you trust, someone who understands your health care concerns, and someone you believe will actively and effectively carry out your health care wishes.

State law does impose some limitations on individuals serving as health care agents. For example, if you live in a residential health care facility or hospital, the operator, administrator, or employee of that facility or hospital cannot serve as your health care agent (unless that operator, administrator or employee is related to you by blood, marriage or adoption). Also, absent a relationship to you by blood, marriage or adoption, any doctor affiliated with your residential health care facility or hospital cannot serve as your health care agent. In addition, an individual who is already serving as a health care agent for ten or more principals cannot be your health care agent unless such person is your spouse, child, parent, brother, sister, or grandparent.

Can I ask my doctor to serve as my health care agent?

As long as your doctor is not associated with a health care facility or hospital in which you reside, she or he can serve as your health care agent. However, the doctor you designate as your health care agent cannot also be the doctor responsible for determining when you lack capacity to make your own health care decisions. Such determination must be made by a second independent physician.

How can I be certain that my wishes, whether contained in a health care proxy, living will, or MOLST form will be respected?

Both a health care proxy and a living will serve as substantial evidence in a court of law of your intentions concerning health care decision making. However, general instructions about refusing treatment, even if written, may not be effective. Therefore, although it is often difficult to anticipate future medical needs, it is best to be as specific as possible about the kinds of treatment you do not want and the medical conditions under which you would refuse those treatments.

If you do not wish to be kept alive by artificial means, it is important to state your intention in both your health care proxy and your living will documents.

The law states that unless your agent is aware of your wishes about artificial nutrition or hydration, she or he will not be allowed to refuse or consent to these matters for you. Therefore, if you are sure that you do not want to be artificially fed or hydrated, you should put specific language concerning the withholding of these interventions in your health care proxy. The following language might be used to express such an intention:

> *My agent knows my wishes concerning artificial hydration and nutrition and is authorized to make such decisions.*

Your living will is the document in which you can set forth in further detail under what circumstances life support can be withheld or withdrawn (specifically as relates to artificial nutrition or hydration), as well as to discuss other types of health care treatment, including:

- Artificial respiration,
- Cardiopulmonary resuscitation (CPR),
- Administration of anti-psychotic medication,

- Palliative care,
- Electric shock therapy,
- Antibiotic treatments,
- Psycho-surgery,
- Dialysis,
- Organ transplants,
- Blood transfusions,
- Abortion, and
- Sterilization.

To assist in making sure your wishes concerning health care are enforced, you should sign multiple originals of the health care proxy and living will forms. You should then furnish duplicate originals of both your living will and health care proxy to the primary and successor agents you designated in the proxy, as well as to your primary care physician for immediate placement in your medical file. Your attorney should also retain a copy of your health care proxy and living will. You may also want a member of your clergy to hold original copies of these documents for you.

Finally, in 2008, Governor Paterson signed legislation allowing the use of Medical Orders for Life-Sustaining Treatment (MOLST) primarily intended for persons facing end-of-life decisions. The MOLST form gives specific instructions to medical personnel regarding treatment. A MOLST form is enforceable as it is a medical order, signed by a physician.

Can anyone make health care decisions for me if I do not have a Health Care Proxy or Living Will?

New York passed the Family Health Care Decision Act, which became effective June 1, 2010. The law allows the appointment of a spouse or domestic partner, adult child, parent, adult sibling or close friend to be designated as a surrogate with authority to make medical decisions for an individual not able to make their own decisions concerning their health care. This includes the right to withhold or withdraw life-sustaining treatment, including artificial nutrition and hydration. The law is effective only if the patient is in a hospital, nursing home or hospice setting. The law fills in some gaps if an individual does not have a health care proxy; however, because of the delays inherent in deciding who is an appropriate surrogate under the Family Health Care Decision Act, it is preferable for all individuals to have a health care proxy.

What is palliative care?

Palliative care is the specialized health care treatment including interdisciplinary end-of-life care, and consultation with patients and family members, to prevent or relieve pain and suffering and to enhance the patient's quality of life including hospice. Palliative care is appropriate at any stage of a serious illness, whether that illness is potentially curable, chronic or life-threatening.

This type of care is focused on providing patients with relief from the symptoms, including the pain and stress of a serious illness, assisting with medical decisions and establishing goals of care – **whatever the diagnosis and regardless of the prognosis. The goal of palliative care is to improve quality of life for the patient, and family and caregivers.** Palliative care is provided by doctors, nurse practitioners, nurses, social workers and other practitioners who work with a patient's health professionals to provide an extra layer of support. Palliative care is appropriate at any age and at any stage of a serious illness, and can be provided together with curative treatment. Palliative care is covered by Medicare, Medicaid and most commercial insurance.

Has any legislation been passed in New York State concerning palliative care?

The Palliative Care Information Act was executed and became effective in February 2011 and is a critically important patient's rights law and a model for the nation. Seriously and terminally ill patients now have a clearly defined right to receive information and counseling about their palliative care and end-of-life options, including hospice, enabling them to make informed treatment decisions.

What information should attending health care practitioners offer as a result of the new Palliative Care Information Act legislation?

The new law requires them to provide information and counseling regarding palliative care and end-of-life options appropriate to the patient, including:

- Prognosis
- Range of options appropriate to the patient
- Risks and benefits of various options
- Patient's "legal rights in comprehensive pain and symptom management of the end of life"

Appropriate means it must be consistent with the patient's psychosocial circumstances and cultural and religious beliefs. Information needs, patient preferences and options may need to be revisited as the disease progresses. The delivery of palliative care and end-of-life counseling need not, and should not, be the same for every patient. The practitioner should be sensitive to the patient's emotional cues, preferences and ability to absorb information.

What is hospice care?

Hospice care is a formal system of care, specific to end of life for individuals who have a life-limiting illness that is no longer responsive to curative treatment. The patient must be certified by a physician to have approximately 6 months or less to live. Hospice care is provided by certified hospice agencies.

Hospice care is comfort care and is not provided together with curative treatment, but can be provided with palliative care. Hospice care is covered by Medicare, Medicaid and most commercial insurance. The Medicare Hospice Benefit covers nursing care, durable medical equipment, some home health aide services, social work visits, pastoral care and other supportive services for the patient and their family. Hospice care is provided in a patient's home, but can also be provided in nursing homes, assisted living facilities, hospice residences and hospitals. Under the hospice program, your own doctor can continue to participate in your care plan. The Medicare Hospice Benefit also provides bereavement support for 18 months after the passing of the patient.

Can I be admitted to hospice if I lack capacity?

Yes. A health care agent appointed under a health care proxy can consent to hospice enrollment when the patient lacks capacity. The patient must also be certified by a physician that death is likely to occur within six (6) months if the disease runs its natural course to be eligible under the Medicare Hospice Benefit.

FUTURE CARE PLANNING – MANAGING FINANCES AND ASSETS

POWERS OF ATTORNEY

My children would like me to execute a Power of Attorney. Do I need one and who should I appoint?

Everyone should consider signing a power of attorney. A power of attorney is a legal document that allows you (the principal) to appoint another individual (your agent) to act in your place for the purposes stated in the document. Powers of attorney can be used to assist you in managing your day-to-day financial affairs. For example, a power of attorney can grant your appointed agent the authority to write checks on your behalf or to sell or purchase property for you. A power of attorney may also be used to permit someone to act on your behalf in the event of a sudden emergency or to manage your affairs if you should become incapacitated.

A power of attorney is a very powerful document as the person you appoint has control over your assets. Thus, only a person you absolutely trust (e.g., spouse, child, other close family relation, lifelong friend or clergy) should be appointed as an agent in the power of attorney.

A copy of the most current New York State Statutory Power of Attorney Form is included as Appendix E in this booklet.

Can a Power of Attorney be used for health care decision making?

No. Only a health care proxy, discussed in the preceding section, can be used to appoint someone to make health care decisions for you. A power of attorney is used primarily for financial decision making.

Can I limit my Agent's authority to act under a Power of Attorney?

Yes. A power of attorney can be tailored to meet your individual needs. At one extreme, a power of attorney can be general and give your agent unlimited and unbridled discretion to make all decisions for you (except decisions concerning your health care). A power of attorney can also be limited to provide that your agent can act on your behalf only with respect to a particular activity or activities (e.g., act at a real estate closing or manage a particular account).

What is a Durable Power of Attorney? Do I need one?

A durable power of attorney is a power of attorney that continues to be effective even after you are no longer competent to make decisions for yourself. If a power of attorney is not "durable," it cannot be used after the principal (i.e., the person signing the power of attorney) becomes incapacitated. The durability of the power insures that you have someone to take care of your affairs should you ever become incapacitated. If you do not have a durable power of attorney and you become incapacitated, there will be no individual who can act on your behalf or access your individual assets to pay any of the expenses arising from your incapacity. (This includes assets such as an IRA, 401(k) or other retirement accounts, which accounts, although they designate a beneficiary, such beneficiary can only act after your death and not at the time of your incapacity). If you become incapacitated without a durable power of attorney, then only a court appointed guardian may access your assets. The legal proceeding to appoint a guardian is often expensive, time consuming, unpleasant and may result in the appointment of someone you would never want to act on your behalf. Using a durable power of attorney avoids the necessity of a guardianship.

How do I know if the Power of Attorney I have is durable?

In New York State, a power of attorney containing language which states that "this power of attorney shall not be affected by the subsequent disability or incompetence of the principal," or similar language, confirms that the power of attorney is durable. You should check any of your existing powers of attorney to make sure they have durability language. Failure to include such language means that the power of attorney you have signed will no longer be valid if you become incapacitated.

Does New York State have a standardized Power of Attorney Form?

Yes. Effective September 1, 2009, New York State adopted legislation authorizing the use of a new statutory power of attorney document which is required to be recognized by all financial institutions authorized to do business in New York State. This power of attorney is durable unless the principal states otherwise in the document. The New York State legislature adopted technical corrections to the Power of Attorney form which became effective September 13, 2010. **A copy of this Statutory Power of Attorney Form is included as Appendix E in this booklet.**

Are Powers of Attorney properly signed prior to September 13, 2010 still valid?

Yes, if they were signed in compliance with the law prevailing at the time of signing.

Can you make changes to the new Statutory Power of Attorney?

Yes, but only if such changes are incorporated in a special "Modifications" section of the power of attorney set forth in subsection (g) of the document. No changes are permitted to be made to the new statutory power of attorney unless expressly set forth in this Modifications section.

Does the new Power of Attorney revoke prior Powers of Attorney executed by the Principal?

No, not unless the power of attorney specifically states so. It is sometimes suggested that the power of attorney state that only prior general powers of attorney be revoked and that powers of attorney used for a specific purpose (i.e., powers of attorney designated for use at a particular financial institution or limited to a specific purpose) not be revoked.

Can the Principal appoint someone to oversee the actions of the Agent under the Power of Attorney?

Yes. Under the new power of attorney legislation, the principal may appoint a "Monitor" to oversee the activities of the agent. The monitor may demand that the agent furnish the monitor with a record of all transactions which the agent has completed on behalf of the principal and the agent must comply with such demand.

Can the Agent be compensated for the work it performs on behalf of the Principal?

Yes. The agent is entitled to reimbursement for all reasonable expenses incurred on behalf of the principal. The agent may also be reasonably compensated for services rendered on behalf of the principal pursuant to compensation terms further specified in the Modifications sections of the power of attorney.

Can the Agent still make gifts of the Principal's assets in the Statutory Power of Attorney?

Yes, but only in the amount of $500 per year unless subsection (h) of the power of attorney is initialed by the principal directing that gifts be made pursuant to the terms of a Statutory Gifts Rider ("SGR") which is annexed to the power of attorney and is also annexed as part of Appendix D in this booklet.

What sort of gifts is the Agent authorized to make on behalf of the Principal in the SGR?

If subsection (a) of the SGR is initialed by the principal, the agent may only make gifts to the principal's spouse, children and more remote descendants and parents not to exceed the annual gift exclusion amount (which is currently $14,000 per person per year).

May the Agent make gifts of the Principal's assets to individuals other than immediate family and in amounts exceeding the annual gift exclusion amount?

Yes, but only if the principal initials subsection (b) of the SGR entitled "Modifications" and then identifies those individuals or charities to whom the agent may gift and specifies the nature and amount of the gifts permitted

May the Agent make gifts of the Principal's assets to him or herself?

Yes, but only if the principal initials Section (c) of the SGR expressly authorizing the agent to make gifts to him or herself.

Should I consider authorizing my Agent in the Power of Attorney to make gifts of my assets to him or herself or others?

Maybe. New York State law states that unless the power of attorney expressly authorizes the agent to make gifts of the principal's assets, the agent does not have such authority. If your estate is of a size in which you had been or would be making gifts to reduce your estate tax liability or if you had been or would be making gifts of your assets in order to qualify for Medicaid in the event you suffered a long term

custodial care health care crisis, then you should consider including in your power of attorney and SGR express language giving your agent the authority to gift your assets to those individuals or charities whom you would wish to benefit.

Should there be a monetary limit on the value of the Principal's assets which the Agent is authorized to gift in the Power of Attorney?

Provided that you have full faith and trust in your agent, the principal may want to authorize the agent in the power of attorney and SGR to make gifts in unlimited amounts to a specific group of individuals and/or charities designated by the principal to be the beneficiary of his or her assets. Such expansion of the gift giving power may allow the principal to achieve estate tax reduction and/or Medicaid qualification. The agent should always be advised to consult with an elder law attorney and/or tax advisor prior to actually making such gifts.

When does a Power of Attorney become effective, and how long does it remain effective?

Unless the power of attorney is a "springing power" which expressly states that it will become effective at a specified moment in the future, a power of attorney becomes effective immediately upon its execution. All powers of attorney executed beginning on September 1, 2009 must be executed by both the principal and all primary agents named thereunder. In addition, such signatures must be notarized and, if gift giving is to be authorized, the signature of the Principal on the SGR must be both notarized and witnessed by two (2) witnesses. Thereafter, once an individual signs and delivers a power of attorney to his or her agent, the agent can have immediate access to the principal's assets. A power of attorney is an enormously powerful document, and the agent you select must be someone you trust implicitly. If you prefer that your agent not be given powers immediately, New York State recognizes a springing power of attorney, which becomes effective only on a certain date or upon the occurrence of a certain event. A springing power of attorney might only be activated, for example, upon a physician determining that you are incapacitated. Since both principal and agent need to sign, one way to have a power of attorney become effective at a later date is to have the principal sign it but withhold delivery to the agent(s) until the occurrence of a specific event.

Do I need to have a Power of Attorney if all of my assets are owned jointly with another person?

While the ownership of a joint account with another allows such joint owner of the account, like the agent in a power of attorney, to manage such account during your lifetime, establishment of a joint account with another person may also result in the surviving owner of the account having a right of inheritance in the account at the time of your death. (This is particularly true on accounts which state "JTWROS" meaning that the owners of the account own such account "joint with rights of survivorship" such that each party will inherit such account at the time of death of the other.)

Joint ownership of an account can prove to be problematic in situations in which it was your intention that individuals, other than or in addition to the joint owner, were to receive the assets in the account at your death. Even if your Will states that all of your assets are to be divided equally among multiple individuals, the fact that you own certain assets jointly with another results in those particular assets being distributed automatically, by operation of law, to the surviving joint owner at your death irrespective of the fact that the terms of your Will state otherwise.

Joint ownership of an account may also prove problematic from an estate tax perspective since if one of the joint parties (other than a spouse) were to die, the entire value of the joint account becomes part of the taxable estate of such predeceased joint owner. This is true even if the predeceased joint owner did not contribute any funds to the joint account. The burden to overcome the presumption that the predeceased joint owner did not own 100% of the account is on the executors of the decedent's estate to demonstrate (by furnishing records and otherwise) that the deceased party did not contribute all of the assets to the account and therefore the entire account should not form part of his or her taxable estate.

A Will only controls assets in your individual name and does not control joint accounts or other contract assets, like life insurance or retirement assets, which have designated beneficiaries. A power of attorney ceases to be effective at the time of your death resulting in the assets owned in your individual name during your lifetime being distributed in accordance with the terms of your Will at death. If you intend that multiple beneficiaries share in your estate at death, use of a power of attorney, rather than joint ownership of assets, becomes particularly important.

What about my passwords and other digital assets?

The New York Estates Powers and Trust Law was amended Sept. 29, 2016 to deal with the administration of digital assets upon the death or incapacity of their owner and to give individuals the power to control their digital footprint. A provision discussing how digital assets should be handled can be incorporated into a New York State Durable Power of Attorney. Such a provision grants specific permission to allow the agent to have the power and authorization to access, take control of, conduct, continue, or terminate accounts on digital devices or digital assets, as defined by Article 13-A of the New York Estates Powers and Trusts Law. Such a provision can also detail whether or not you wish to grant your agent the power to obtain log-on credentials, including usernames and passwords for all types of online accounts including but not limited to banking, email and social media.

LIVING OR INTER VIVOS TRUSTS

What is a Living or Inter Vivos Trust?

Like a power of attorney, a living trust(also known as an inter vivos trust) is a legal tool that you can use to plan for the possibility of your future incapacity. To create the trust, you (the grantor) transfer all of your assets into the name of the legal entity known as the trust (e.g., the Jane Doe Trust) and appoint a trustee to manage the trust's assets. The trustee makes all decisions concerning the trust. Generally, income generated by the trust is paid to the grantor on a regular basis. Payments from the principal of the trust are made, within the trustee's discretion, for the support, maintenance, and care of the grantor. Similar to a Will, the trust also details how the trust's assets are to be distributed after the death of the grantor. The most common form of living trust is a Revocable Living Trust which the grantor may revoke at any time.

Trusts can be complicated documents with significant tax ramifications. If you are considering transferring your assets to a trust, it is strongly recommended that you consult with an attorney first.

I am healthy and competent and not comfortable with the idea of having someone else manage my assets right now. Can I serve as the Trustee of my own Living Trust?

Yes. You can name yourself as the trustee of your own living trust and provide for a successor trustee to take over in the event of your incapacity or upon your death. You can also name yourself and an independent third party trustee as co-trustees, and provide that you and the independent trustee will act together to manage the trust until you become incapacitated or die, at which time the independent trustee will take over. Finally, you can appoint a third party trustee to manage the trust assets without your acting as co-trustee, but still maintain control over the trust by reserving the power to terminate the trust at any time.

Can a Revocable Living Trust be used to distribute my assets at death instead of a Will?

Yes. In certain states the revocable living trust, rather than the Will, has become the instrument of choice for distributing assets at death. This is because in certain states the cost of probate (i.e., a legal proceeding to have the court approve a Will at death) is expensive, as it can be equal to as much as 5% or more of your estate. In contrast, a revocable living trust is a private document which permits distribution of assets after death without court approval.

The majority of the states in the United States (including New York) are probate friendly, meaning that the statutory fees to submit the Will to the court for probate approval are reasonable. In New York, the court costs related to a probate filing do not exceed $1,250. In probate friendly states, it may not be appropriate to establish a revocable living trust, since in order for a revocable living trust to save a modest amount of probate fees, an individual must totally overhaul the manner in which his or her assets are owned by currently transferring all assets into the title of the Living Trust. For example, real estate owned in the name of John Smith has to be transferred to the Trust of John Smith, and a bank account in the name of Mary Jones must be transferred to the Trust of Mary Jones. Such costly and time consuming asset transfers, combined with legal fees to establish the trust may outweigh the savings of minimal probate fees.

Are there circumstances where it still makes sense to use a Revocable Living Trust even if you reside in a probate friendly State such as New York?

Absolutely. A revocable living trust may be the preferred estate planning instrument to a Will and more appropriate in the following circumstances:

1. If you own real property in multiple states, the law requires that you probate the Will in each state in which the decedent owned real estate. To avoid probates in multiple states under such circumstances, which could prove to be costly, complicated and time consuming, it may make more sense to establish a single living trust which can own all the real property and more efficiently distribute such property out at death without the need to follow the probate requirements of multiple states.

2. If you do not intend to leave your assets to your heirs at law (also referred to as distributees) and/or the whereabouts of such heirs at law are unknown, the use of a living trust may be preferred so that your estate is not burdened, both financially and otherwise, with the probate notification laws which require having to locate estranged family members to advise them of their rights in your estate even though you have not provided for them in your Will.

3. Where privacy/confidentiality is a concern, use of a living trust may be preferred since unlike a Will, a trust document is not required to be filed with the court and thereby made a public record at death.

4. To provide a more detailed and streamlined asset management tool during life (i.e., more than just a power of attorney which only gives someone general authority to act). A revocable living trust is easy to administer (as it does not even require the filing of separate income tax returns) and will avoid the necessity of guardianship proceedings in the case of future incapacity.

Will the use of a Revocable Living Trust save income or estate taxes?

No. Since the trust is revocable (meaning the trust can be terminated and its assets can be taken back by the grantor at any time), the Internal Revenue Service taxes all income generated by the assets in the same manner as if they were owned in the individual name of the grantor. The Internal Revenue Service has also stated that all assets in a revocable trust form part of the grantor's taxable estate (since the grantor could take the assets back into his or her individual name until the time of the grantor's death) and are subject to estate taxes to the extent the grantor's estate exceeds taxable limits (see Section on "Taxes" discussed later in this publication).

Will the use of a Revocable Living Trust protect the trust assets and allow the Grantor to qualify for Medicaid?

No. Since the grantor can terminate the trust at any time and take the assets back for him or herself, the Department of Social Services considers the assets in the trust to represent part of the overall resources owned by the grantor and will disqualify the grantor from receiving Medicaid assistance to the extent the grantor's resources exceed the Medicaid resource allowance.

What type of Trust will offer tax and asset protection advantages?

An irrevocable trust. An irrevocable trust is a trust in which the grantor has irrevocably transferred his or her assets into the trust and no longer has access to the principal assets placed in such a trust. Similarly, a properly drawn irrevocable trust will protect the principal assets contained in the trust and allow the grantor to qualify for Medicaid after the transfer penalty period has lapsed (discussed later in this publication in the Section entitled "Preservation of Assets/Medicaid Planning"). It is possible for the grantor of the irrevocable trust to retain a right to receive the income generated by the assets owned by the trust (i.e., interest and dividends) and still protect the principal assets in the trust from spend-down in order to qualify for Medicaid in the event of a long term custodial care crisis.

Do I still need a Will if I have a Trust (Revocable or Irrevocable)?

Yes. A Will is always important to have in case there are certain assets which cannot be transferred into trust title (e.g., a co-op which the Board of Directors refuses to transfer) or if assets are discovered which were inadvertently left out of the trust. The Will can direct that such miscellaneous assets be paid to and thereafter distributed in accordance with the terms of the trust at the time of the grantor's death. This type of Will is called a "Pour Over Will" and is important for purposes of controlling those miscellaneous assets still remaining in the grantor's individual name at the time of his or her death. Without a Will, such assets would be distributed in accordance with the intestacy laws of the State of New York, which laws dictate how assets not controlled by a Will or Trust are to be distributed at the time of a person's death (discussed in the following Section on "Wills" in this publication).

WILLS

I am married, have no children, and do not have much property. Do I need a Will?

If you do not have a Will (or a funded trust) to dispose of your assets upon your death, your assets will be distributed according to the New York State intestacy law, irrespective of what you otherwise would have intended. The New York intestacy laws prioritize the distribution of assets, as follows:

a. If survived only by spouse (no children or parents) – everything to spouse,

b. If survived by spouse and parent or parents (no children or grandchildren, great-grandchildren, etc.) – entire estate to spouse,

c. If survived by spouse and any children (or grandchildren of deceased children) – $50,000 plus ½ of estate to spouse and ½ of estate to children or grandchildren,

d. If no spouse, children or parents, then to grandchildren and further descendants, if any,

e. If no descendants as in (d), then to brothers or sisters or their issue, and

f. More remote family relationships extending out to first cousins once removed (sometimes referred to as "laughing heirs" as they would inherit assets not having ever known the decedent).

NOTE: Adopted children and illegitimate children of decedent have same rights as biological and legitimate children (except illegitimate children only have inheritance rights from deceased father if they prove paternity).

Even if your estate is small, a Will can ensure that certain items of personal property are given to specific individuals upon your death. A Will is also useful to provide instructions regarding the disposition of your remains (i.e., your burial, cremation), and whether you want to be an organ donor. If you intend to donate your organs, however, it is best to set forth this intent in a separate document (e.g., the appropriate portion of your New York State driver's license or in your health care proxy as previously discussed), since your Will may not be accessible in a timely manner upon your death and organ donorship requires quick action. Likewise, your funeral arrangements should be set forth in an accessible letter of instructions, since your Will may not be readily available.

If my assets will be distributed by the laws of intestacy to the same people who would inherit my assets if I had used a Will, do I still need a Will?

It is best still to have a Will. If you do not have a Will, a bond will need to be posted at additional cost to the estate before anyone can be appointed to administer your estate. Also, the individual appointed to administer your estate may not be someone who you would want to manage your affairs.

My Will provides for all of my assets to pass to my spouse. I have a joint bank account with my daughter. Who will get the funds in that account when I die?

A Will only controls assets in your individual name. The funds contained in the joint account are not controlled by your Will and will pass to your daughter (unless the account was set up without a survivorship feature). The same is true for other jointly owned real or personal property. In addition, proceeds from life insurance policies or other accounts that have specific designated beneficiaries (e.g., IRA, 401(k) or other retirement accounts, or "in trust for" or "payable upon death" bank accounts) are not controlled by your Will. These assets will pass outside of your probate estate to the designated beneficiaries. These assets are, however, still included in your estate for estate tax purposes.

TAXES

ESTATE & GIFT TAXES

I am married and plan to leave my estate to my spouse. How much of that estate will go to taxes?

The law provides for an **unlimited marital deduction**, meaning a surviving spouse pays no federal or New York State estate taxes if the entire estate is left to a surviving spouse and/or charity. However, when the surviving spouse dies, then the estate may be subject to both state and federal estate taxes.

In those instances where assets are left to someone other than a surviving spouse and/or charity, federal and/or New York State estate taxes may be due on the decedent's estate on that portion of the estate which passes to beneficiaries other than a spouse and/or charity and which amount exceeds the then prevailing federal and/or New York State estate tax exemption amounts discussed below.

What are the laws concerning the Federal Estate Tax?

The new Tax Cuts and Jobs Act which took effect on January 1, 2018 (the "Tax Act") modified the existing laws concerning estate and gift taxes. Significantly, the Tax Act increased the amount which may be exempted from federal estate tax to $11.58 million dollars per person (or $23.16 million dollars for a married couple) which amount is subject to further annual adjustment based on inflation. This increased exemption expires at the end of 2025 at which time the exemption would reduce back down to $5.62 million dollars per person (adjusted for inflation) unless new legislation was adopted. Notwithstanding, the increased exemption amount, the 40 percent tax rate continues to apply to the value of that portion of the estate in excess of the exemption amount.

The Tax Act further continues the law of portability which allows the surviving spouse to use or "port over" to himself or herself any unused portion of the estate tax exemption amount of the predeceased spouse as part of the surviving spouse's exemption when such survivor dies.

In addition, the Tax Act continues to unify the gift and estate tax exemptions. Thus, the lifetime gift tax exemption is also $11.56 million dollars and is indexed for inflation. Notably, unlimited gifts may be made to a spouse or charity without any gift tax consequence just as there is no estate tax assessed on assets passing from a decedent to a spouse or charity. As a result each person may now make up to $11.56 million dollars of gifts (in addition to the $15,000 per person annual gift exclusion amount) before being subject to tax and may make unlimited gifts to a spouse or charity. It is important to understand, however, that any gift made (other than the tax exempt gifts made to a spouse or charity) which are over $15,000 per person per annum will reduce the estate tax exemption on a dollar for dollar basis. Therefore, if one was to make gifts totaling $2 million dollars during their lifetime (in excess of the $15,000 per person annual exclusion amount) and the estate tax exemption was still at the time of such persons death equal to $11.56 million dollars, then such person will only have a $9.56 million dollar exemption at death.

However, the advantage of making such a gift is that any appreciation in the value of the gifted assets will occur outside the taxable estate and thus the loss of $2 million dollars of estate exemption may be insignificant if the assets grew to be valued at $5 million dollars at the time of the donor's death as such appreciated value of $3 million dollars is not subject to estate tax. Thus, the ability to make larger gifts without paying up front gift tax combined with the ability to continue to do minority and other discount planning in a low interest rate environment may result in the ability to transfer large sums of wealth to succeeding generations without being subject to gift or estate tax.

What are the laws concerning the New York State Estate Tax?

In addition to the federal estate tax referenced above, estates of individuals who are residents of the State of New York at the time of their death may be subject to a separate state estate tax if the Decedent's assets are passing to someone other than a spouse or to a charitable entity.

Effective April 1, 2014 New York State adopted sweeping changes to its state estate tax law which previously had taxed estates passing more than $1 million dollars to non-spousal and non-charitable beneficiaries. Under the 2014 Legislation,

the New York State estate tax exemption amount (referred to as the "exclusion amount" under New York law and so referred to in this publication) incrementally increased over time from April 1, 2014 through December 31, 2018.

Currently, the New York State exclusion amount is $5.85 million dollars and will remain at that amount through December 31, 2020 after which time it will continue to be indexed and adjusted to account for inflation.

Under the existing legislation, those estates valued at more than the $5.85 million dollar New York State estate tax exclusion amount will continue to pay a separate New York State estate tax. Significantly, however,for those estates which are valued at more than the$5.85 million dollar exclusion amount , there will be a New York State estate tax calculated based on the full value of the estate rather than just on the amount exceeding the exclusion amount as had been past practice.

Such calculation has a "cliff effect" and can be confiscatory in nature. For example, assume an individual dies on June 1,2020, when the New York exclusion amount is $5.85 million dollars. If that individual had a New York taxable estate of $6,000,000 (which only exceeds the then prevailing $5.85 million dollar exclusion amount by $150,000), that estate would pay $333,128 in New York estate tax. If that individual had instead died with an estate valued at $5.85 million dollars, however, the estate would have owed no New York estate tax. Thus, there would be New York estate tax of $333,128 (at a marginal New York estate tax rate of over 222%) on the additional New York taxable estate of $150,000 in excess of the basic exclusion amount of $5.85 million dollars.

Based on the above, it is of critical importance that a careful analysis of the value of an estate be conducted so steps can be taken through gifting, disclaimer or other strategies to reduce the New York State estate tax liability

Are gifts I give while I am alive also taxed?

You can give unlimited separate gifts of $15,000 per year ($30,000 per year for married couples) to as many friends or family members as you would like without any tax consequences. These gifts are referred to as the annual exclusion amount and are not income to the recipient. However, any income (i.e., interest and dividends) generated by the gifts after transfer are taxed to the recipient.

The Tax Act and subsequent inflation adjustments increased the lifetime gifting amount to a maximum amount of $11.58 million dollars per person. The Tax Act and subsequent inflation adjustments imposes a separate federal gift tax on the amount over the $11.58 million dollar gift tax exemption amount at a rate not to exceed 40%. New York State does not impose a separate gift tax but instead adds back certain federally taxable gifts made during the lifetime of a Decedent which may cause additional estate tax to become payable.

Once you give any individual or entity (other than a spouse or charity), in any one year, more than $15,000 (or $30,000 for a married couple), you are obligated to file a federal gift tax return as such gifts constitute taxable gifts. In addition, there is an interplay between the gift and estate tax laws such that the amount gifted over $15,000 (or $30,000 for married couples) reduces the lifetime estate tax exemption amount of the maker of the gift. For example, if you gave any one individual, in any one year, $20,000 instead of the $15,000 annual exclusion amount, your $11.58 million dollar lifetime federal estate tax exemption and $5.85 million dollar New York State estate tax exclusion which exists in 2020 would be reduced by the $5,000 excess over $15,000 or down to $11.53 or $5.80 million dollars, respectively.

If the excess gifts ever totaled more than the $11.58 million dollar lifetime federal gift tax exemption amount, an upfront federal gift tax would have to be paid at a rate of 40% on such excess. In addition, an estate tax would be paid on the decedent's estate to the extent the value of the decedent's estate exceeds the estate tax exemption amount (in the year of the decedent's death) as reduced by the amount of gifts made over the annual exclusion amount during the decedent's lifetime.

Although New York State had abolished its separate gift tax in the year 2000, the new New York legislation has resulted in New York State adding to the taxable estates of its decedents dying beginning on April 1, 2014 through December 31, 2025 the value of all taxable gifts made during the three (3) year period preceding death. This "add back" provision applies to both real estate and tangible personal property located in New York State.

What can I do to reduce taxes due on my estate?

As an individual

If your estate exceeds the then prevailing Federal or New York State estate tax exemption, you can act during your lifetime to reduce the value of the estate by making tax free gifts of $15,000 per year ($30,000 for a married couple) to as many friends or family members as you would like. Larger gifts may be contemplated, particularly of assets likely to appreciate, so such appreciation occurs outside of the donor's taxable estate. In addition, an individual may want to consider gifting larger amounts (not to exceed the $11.40 million dollar lifetime federal gift tax exemption as a gift of that magnitude would cause an immediate federal gift tax to be due). The gifting of such amounts will not result in the imposition of gift tax and may lower the overall estate tax liability at death (although special consideration must be given to those gifts made within three (3) years of their death as previously discussed). There are also other estate tax reduction strategies (e.g., life insurance trust, split interest trusts and discount planning) which may be applicable but are beyond the scope of this publication and should be explored with a skilled estate planning attorney or tax advisor.

As a married couple

In 2020, a married couple is able to take advantage of the $11.58 million dollar per person federal exemption amount and exempt up to $23.16 million dollars over their joint lifetimes by implementing proper estate planning

One important planning strategy that continues to be viable in the new Tax Act is "portability." Please note that portability is only permitted under federal law and is not permitted for New York resident decedents.

Portability is a concept which allows for the executor of the deceased spouse's estate to transfer any unused portion of the current $11.58 million dollar federal estate tax exemption belonging to such spouse's estate to the surviving spouse. Thus, if the first spouse to die had an estate of $9.58 million dollars which was bequeathed to the couple's children, then the unused portion of such predeceased spouse's $11.58 million dollar estate tax exemption (i.e., $2 million dollars) could

be "ported over" to the surviving spouse. This would allow the surviving spouse to have a $13.58 million dollar estate tax exemption at the time of his or her subsequent death consisting of the surviving spouse's $11.58 million dollar exemption plus the $2 million dollar unused portion of the predeceased spouse's estate tax exemption. Thus, $23.16 million dollars passes to the next generation estate tax free as a result of the fact that $9.58 million dollars of the estate tax exemption was used up by the estate of the first spouse to die and the remaining $13.58 million dollars was used up by the surviving spouse's estate.

For portability to be effective, the executor of the estate of the first spouse to die must make an affirmative election on the estate tax return of the predeceased spouse (which must be filed within 9 months of such spouse's death) stating that the surviving spouse wishes to transfer to him or herself the unused portion of the predeceased spouse's estate tax exemption. Filing of these portability elections will become very important in spousal cases as even if the first spouse to die has very modest net worth, the surviving spouse is going to want to make sure that the unused portion of such predeceased spouse's exemption is transferred to him or her to exempt as much of the value of the survivor's estate as possible from estate taxation.

However, to maximize the use of the New York State estate tax exemption (since portability is only recognized for federal and not New York State estate tax purposes) and to plan for any future federal tax changes that may eliminate large exemptions and portability, married individuals may elect to incorporate a Credit Shelter Trust in their Wills so that they can exempt two times the estate tax exemption amount (currently $23.16 million dollars for federal estate tax purposes or $11.70 million dollars for New York State estate tax purposes in 2019) from estate taxation.

Without portability being available, leaving assets directly to one's spouse outright will still result in there being no estate tax at the time of the death of the first spouse, but all of the assets left to the surviving spouse will become part of such survivor's estate, and will be subject to applicable estate taxes upon that spouse's subsequent death. If a credit shelter trust is established, the assets of the first spouse to die may be deposited to that trust and still be exempt from the payment of federal estate taxes at the time of that spouse's death.

In addition, even in instances where portability is still applicable, credit shelter trusts may still be employed to avoid having the assets go directly to the surviving spouse and have such assets be subject to the claims of such survivor's creditors or the uncertainties of remarriage.

The use of the Credit Shelter Trust in a Will effectively allows a husband and wife to collectively shelter up to $23.16 million dollars of their assets from federal estate taxes and $11.70 million dollars from New York State estate taxes (i.e., 2 x the $11,580,000 federal exemption or 2 x the $5,850,000 New York State exemption amount which exists in 2020). This sheltering occurs since:

1. At the time of the death of the first spouse, the surviving spouse can decide not to accept up to the first $5.85 of the assets of the deceased spouse for New York State estate tax purposes or $11.58 million dollars for federal estate tax purposes in 2019 and instead have such assets fall into a credit shelter trust exempt from tax both in the estates of the deceased spouse and the surviving spouse and thereafter; and

2. The surviving spouse's own personal exemption removes the second sum of $5.85 or $11.58 million dollars from his or her taxable estate

A Credit Shelter Trust may provide for all income from the trust's assets to be paid to a surviving spouse during his or her lifetime. The trust principal may be made available for direct withdrawal by the surviving spouse (in annual amounts not to exceed 5% of the trust principal), if the surviving spouse so elects, or if larger amounts are needed by the surviving spouse, such additional amounts may be withdrawn by the surviving spouse for their health, education, maintenance or support as they so determine or may be distributed to such spouse for other purposes as determined within the sole discretion of an independent trustee. Upon the death of the surviving spouse, the trust's principal (i.e., the exemption amount of assets contained in the trust and all appreciated value of such assets) pass to the trust's beneficiaries(children or other individuals) estate tax free

To maximize flexibility and allow for consideration of future income tax or other considerations, a Will can also provide for a type of Credit Shelter Trust which only becomes funded at the option of the surviving spouse. Such a credit shelter trust is referred to as a renunciation or disclaimer credit shelter trust and may be an appropriate estate planning strategy which a married couple may want to discuss with a skilled estate planning attorney or tax consultant.

SECURE ACT FOR RETIREMENT PLANNING

What is a required minimum distribution ("RMD")?

The Internal Revenue Code (the "Code") requires retirement plan participants to take certain annual distributions from retirement plans beginning generally at age 72.

The RMD is the amount that must be distributed in a particular year to a plan participant from the participant's retirement plan.

Which retirement plans are subject to the RMD rules?

The RMD rules apply to qualified retirement plans. Types of qualified retirement plans include traditional IRAs, simplified employee pension (SEP) IRAs, savings incentive match plans for employees (SIMPLE) IRAs, 401(k) plans, 403(b) plans, 457(b) plans, profit sharing plans and other defined contribution plans.

Why do we care about RMDs?

Retirement plans allow participants to accumulate funds inside the plans on a tax-deferred basis. Investing through a retirement plan allows a participant to defer income tax not only on the participant's compensation that was originally contributed to the retirement plan, but also to defer paying tax on the growth of and the income earned on the participant's compensation contributed to the plan. Thus, amounts contributed to retirement plans, as well the growth and earnings from amounts contributed, are sheltered from tax until they are distributed to the participant or the participant's beneficiaries.

The RMD rules dictate when this tax-sheltered accumulation must ends and when funds must begin being distributed from a retirement plan. These same rules direct how much must be distributed each year.

Once funds are distributed from a retirement plan, those amounts are taxed. Until the participant's compensation and the amount that is earned investing that compensation is distributed, it grows tax-free.

Keeping the funds in the plan enables the participant or beneficiary to reap a profit from investing the original compensation and the income earned on that compensation.

Thus, the more time that the funds in a retirement plan are allowed to remain in the plan without distribution, the more the funds will grow.

When were RMDs required to be made prior to the enactment of the SECURE Act?

Prior to the passage of the Setting Every Community Up for Retirement Enhancement ("SECURE") Act, the retirement plan participant would begin taking RMDs at age 70½. Upon the death of a retirement plan participant, the balance of the participant's retirement account generally had to be distributed in annual installments over the life expectancy of the participant's designated beneficiary.plans.

A retirement plan participant could make his or her retirement plan payable to a designated beneficiary and the designated beneficiary could leave the plan in its tax-deferred status for years after the participant's death, withdrawing the benefits only gradually by taking annual distributions over the beneficiary's life expectancy.

For example, a 50-year-old beneficiary could have more than 30 years to withdraw amounts in a participant's retirement plan.

If the retirement plan was not left to a designated beneficiary (e.g., the estate of a retirement plan participant), the inheritor had to withdraw the benefits within five years after the participant's death if the participant died before the participant's required beginning date (i.e., age 70½ before SECURE Act) or in annual installments over what would have been the remaining life expectancy of the participant if the participant had not died.

Special rules existed for the surviving spouse of the plan participant that still exist today under the SECURE Act. Surviving spouses had, and still have, the option to roll over the inherited benefits to the surviving spouse's own retirement plan.

The SECURE Act changes these rules.

What does the SECURE Act generally provide?

The SECURE Act generally applies to retirement plan participants who have invested in retirement plans and die after December 31, 2019.

Under the SECURE Act, with the exception of the five particular types of beneficiaries discussed below, when a retirement plan participant dies, beneficiaries of the retirement accounts will be required to distribute the entire inherited retirement account balance by the end of the tenth calendar year following the retirement plan participant's death.

In the interim, no distributions are required, as long as the funds are completely distributed from the plan by December 31 of the year that contains the tenth anniversary of the participant's date of death.

Thus, the distribution of funds from a participant's retirement plan can take place in up to 10 annual installments to manage the related income tax liability, or deferred in full until year 10.

When must RMDs begin under the SECURE Act?

Prior to the enactment of the SECURE Act, participants in retirement plans were required to begin taking RMDs at the age of 70½ according to life expectancy tables provided by the Internal Revenue Service.

The SECURE Act raises the required starting age for retirement account distributions to age 72. During life, a retirement plan participant must generally begin taking withdrawals by April 1 of the year after the participant reaches age 72.

This change applies to RMDs required to be made after December 31, 2019 for individuals who turned age 70½ after that date. Individuals who were 70½ before that date cannot take advantage of the change in RMD start date.

The increase in the required starting age enables retirement plan participants to increase the tax-deferred growth inside their retirement accounts.

Once the plan participant dies, the 10-year rule generally takes effect and the remaining account balance must be distributed to designated beneficiaries within 10 years after the participant's date of death.

What are the exceptions to the 10-year rule?

The 10-year rule does not apply to certain eligible designated beneficiaries.

An eligible designated beneficiary is an individual who, with respect to the retirement plan participant, on the date of his or her death is: (1) the surviving spouse of the plan participant; (2) a child of the plan participant who has not reached the age of majority; (3) a disabled individual; (4) a chronically ill individual; or (5) any other individual who is not more than 10 years younger than the plan participant.

A surviving spouse can also still roll over retirement plan benefits into the surviving spouse's own retirement plan upon the death of the participant spouse and stretch distributions over the surviving spouse's lifetime. In that case, the surviving spouse can name his or her own designated beneficiary for the rollover retirement plan.

After the surviving spouse's death, the SECURE Act will apply to the accumulated funds in the surviving spouse's retirement plan.

In order to be considered an eligible designated beneficiary under this exception, the surviving spouse must have been legally married to the decedent.

How does the "minor child of the plan participant" exception work?

The SECURE Act provides that a child of a deceased retirement plan participant who is the sole designated beneficiary of the plan and has not reached the age of majority is an eligible designated beneficiary.

Once the child attains the age of majority, then the 10-year rule starts. When the child reaches the age of majority, anything remaining in the inherited plan must be distributed within 10 years after that date. This changes distributions from annual distributions over the life expectancy of the child to discretionary distributions completed by the end of the tenth year after the child reaches the age of majority.

For example, Agatha dies in 2020, leaving her IRA to her minor child William. William's guardian must withdraw benefits annually from the IRA starting in 2021, the year after Agatha's death, using the pre-SECURE Act life expectancy payout method computed based on the age William will attain on his birthday in 2021. If William reaches the age of majority on August 9, 2028, that is the final year the RMD will be based on the life expectancy payout. William will have to withdraw the rest of the IRA using the 10-year rule, meaning the IRA must be completely distributed to him no later than December 31, 2038. If William dies

after attaining the age of majority but before the end of the 10-year period, his successor beneficiary will have to withdraw the remaining funds in the IRA over what is left of William's 10-year period. If William dies before attaining the age of majority, the 10-year payout to his successor beneficiary will begin the year after William's death.

Only a child of the deceased participant, and not a grandchild or stepchild, will qualify under this exception.

To permit life expectancy distributions for a minor child prior to reaching the age of majority, the child must be the sole designated beneficiary of the plan.

As far as when a child will be considered to have reached the age of majority, some uncertainty exists. Generally, when a minor reaches the age of majority is a matter of state law. Most states deem an individual to have reached the age of majority upon turning 18. Alabama and Nebraska set the age of majority at age 19, while Mississippi considers an individual a minor until they reach the age of 21. However, the SECURE Act provides a reference to the Code and Treasury Regulations which extends the age of majority "if the child has not completed a specified course of education and is under the age of 26." This could extend the age of majority to the age of 26 if the child is enrolled in college or graduate school.

What are the "disabled individual" and "chronically ill individual" exceptions?

A disabled or chronically ill beneficiary is considered an eligible designated beneficiary and is not subject to the 10-year rule. The life expectancy payout applies to the disabled individual and, upon his or her death, the 10-year rule starts.

A person is considered "disabled" if he or she "is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or to be of long-continued and indefinite duration."

Thus, individuals who are only partially disabled or whose disability does not prevent them from engaging in substantially gainful activity would generally not qualify. A person is considered as unable to engage in substantial gainful activity if not able to earn more than a certain defined monthly amount.

A person is deemed "chronically ill" if the individual has been certified by a licensed health care practitioner as a person who is unable to perform, without substantial assistance from another individual, at least two activities of daily living for a period of at least 90 days due to loss of functional capacity. The six activities of daily living include eating, toileting, transferring, bathing, dressing and continence. The beneficiary must meet the definition as of the participant's date of death. Additionally, the licensed health care practitioner must expect the chronic illness to continue for an indefinite and lengthy period of time.

The beneficiary's status as disabled or chronically ill is determined as of the date of the participant's death. Thus, an able designated beneficiary who becomes disabled at a later date is not entitled to switch over to a life expectancy payout.

How does the "not more than 10 years younger than the decedent" exception work?

This exception is fairly straightforward. A beneficiary who is not more than 10 years younger than the deceased retirement plan participant can continue to stretch distributions from a plan during the beneficiary's lifetime without regard to the SECURE Act's 10-year rule.

The exception permitting a life expectancy payout for a beneficiary who is not more than 10 years younger than the deceased participant ends at the death of the beneficiary.

Beneficiaries who may benefit from this exception include siblings, parents and unmarried partners of the deceased participant.

What happens if an eligible designated beneficiary dies before the 10-year rule expires?

Upon an eligible designated beneficiary's death, the remainder of a participant's retirement plan must be distributed within 10 years after the death of the eligible designated beneficiary. Thus, the 10-year rule applies after the death of the eligible designated beneficiary.

For example, if a disabled child of a plan participant is an eligible beneficiary of a parent who dies when the child is age 25 and the child dies at age 35, the beneficiary of the disabled child's remaining beneficiary interest must be distributed by the end of the year of the tenth anniversary of the death of the disabled child.

If a child is an eligible beneficiary based on having not reached the age of majority before the participant's death, the 10-year rule applies beginning with the earlier of the date of the child's death or the date that the child reaches the age of majority. The child's entire interest must be distributed by the end of the tenth year following that date.

What happens if a participant designates his estate, certain trusts or a charity (a "non-designated beneficiary") as the beneficiary?

If a deceased retirement plan participant did not designate a beneficiary of his funds in the plan, the funds will be distributed to the estate of the deceased participant and distributed pursuant to the Last Will and Testament of the deceased participant if he had a Will or, if he did not have a Will, then by the laws of intestacy of the State in which the participant died.

In that case, if the participant died before the participant's required beginning date (i.e., the date funds must begin to be distributed from the plan – now age 72), then the beneficiary must withdraw all of the retirement account within five years of the deceased participant's death.

If the participant died after the participant's required beginning date, then the beneficiary's RMD is based on the deceased participant's life expectancy immediately before death.

MEDICARE

What is Medicare?

Medicare is a federal non means-tested health care program for qualified persons over 65 and recipients of Social Security Disability (SSD) benefits. Generally, a qualifying work history for you or your spouse is required and you must either be over 65 years of age or in receipt of Social Security Disability benefits for more than two years to enroll in Medicare. Medicare has no income or resource limits; however, it does require co-payments and has deductibles for most services.

Medicare Part A covers hospitals, home health care, and time-limited nursing home costs. Most people get Medicare Part A for free, which is based on the amount of time you (or a spouse or parent) paid Medicare taxes while working.

Medicare Part B covers non-hospital costs such as doctor visits, and ambulance and outpatient services. Medicare Part B requires a monthly premium based on income.

Medicare Part D, introduced in 2005, provides prescription drug coverage for Medicare recipients through private insurance companies. Premiums are required and coverage varies from provider to provider.

What does Medicare cover?

In general, **Part A** covers:

- Hospital care;
- Skilled nursing facility care, for up to 20 days without co-pays, and up to an additional 80 days with co-pays;
- Hospice; and
- Home health services; however only skilled and rehabilitative services are covered, not custodial care. The care must be part-time and intermittent.

Part B covers:

Medically necessary services: Services or supplies that are needed to diagnose or treat your medical condition and that meet accepted standards of medical practice are covered.

Preventive services: Health care to prevent illness (like the flu) or detect it at an early stage, when treatment is most likely to work best, are covered and being expanded.

Part B also covers items such as:

- X-rays;
- Ambulance services;
- Durable medical equipment (DME);
- Mental health treatment;
- Lab costs;
- Getting a second opinion before surgery; and
- Limited outpatient prescription drugs.

Part C

Also known as Medicare Advantage, Part C is a comprehensive plan which combines Parts A, B, and D in one private insurance plan.

Part D (Prescription Drug Plans)

Each Medicare Prescription Drug Plan has its own list of covered drugs (called a formulary). Many Medicare drug plans place drugs into different "tiers" on their formularies. Drugs in each tier have a different cost. A drug in a lower tier will generally cost less than a drug in a higher tier. In some cases, if a drug is on a higher tier and your prescriber thinks you need that drug instead of a similar drug on a lower tier, you or your prescriber can ask your plan for an exception to get a lower co-payment.

How do I enroll in Medicare?

People under age 65 receiving Social Security Disability payments will automatically be enrolled in Medicare Parts A and B after two years. People receiving Social Security retirement benefits are automatically enrolled in Medicare Parts A and B. If you are not receiving Social Security payments, you can enroll in Medicare by contacting the Social Security Administration when you reach age 65.

When is Medicare Open Enrollment?

Medicare's Open Enrollment period is October 15 - December 7. During this period is when ALL people with Medicare can change their Medicare health plan and prescription drug coverage. Information on available plans will be available beginning in October. People with Medicare can visit www.medicare.gov for plan information. If a person is satisfied that their current plan will meet their needs for next year, they do not need to do anything.

What if I don't have enough income to pay Medicare Part B or Part D premiums?

A program administered by Medicaid called the Medicare Savings Program is available to those who meet certain income guidelines. This program will pay for Part B premiums and may also pay for Medicare deductibles, coinsurance, and co-payments. Similarly, a program called Extra Help is available to low-income individuals to pay Part D premiums and deductibles. Finally, EPIC, a NYS pharmacy assistance program, will pay the Medicare Part D premium for members with income up to $23,000 if single or $29,000 if married. Higher income members are required to pay their own Part D premiums but EPIC provides premium assistance by lowering their EPIC deductible.

Do I need a supplemental (Medigap) policy?

A Medicare supplement (Medigap) insurance, sold by private companies, can help pay some of the health care costs that Medicare doesn't cover, like co-payments, co-insurance, and deductibles.

Some Medigap policies also offer coverage for services that Medicare doesn't cover, like emergency medical care when you travel outside the U.S. If you have Medicare and you buy a Medigap policy, Medicare will pay its share of the Medicare-approved amount for covered health care costs. Then your Medigap policy pays its share.

Is my Medicare being changed by the Affordable Care Act?

Yes, the Affordable Care Act is closing the gap in prescription drug plans when the Part D coverage limit is exceeded (the "doughnut hole"), and increasing preventive care coverage. You do not have to enroll in a new insurance program to get this coverage. In fact, it is illegal for a representative of a **Health Insurance Marketplace** to sell **Qualified Health Plan** coverage to a person receiving Medicare.

Will Medicare pay for long term care?

No, Medicare will not pay for extended periods of home care, custodial care, or a long term skilled nursing facility.

LONG TERM CARE INSURANCE

Do Medicare and Medigap insurance cover all types of medical care?

Medicare and Medigap insurance cover skilled medical care services but not prolonged custodial care services.

What is custodial care?

Custodial care is care required to assist an individual with his or her activities of daily living (e.g., care during recovery from a stroke or while suffering from Alzheimer's disease or other dementia). Activities of daily living include eating, bathing, dressing, transferring or mobility (e.g., moving from a bed to a chair) and toileting.

Do Medicare and Medigap insurance cover any custodial care costs?

Such insurance may cover custodial care in a skilled nursing facility for a maximum of 100 days following a hospitalization of at least 3 days duration, provided the doctor's plan of care contains a rehabilitative component and it can be shown that the patient is being benefited by such rehabilitation. The first 20 days of such care will be fully paid for by Medicare. The remaining 80 days of such care are subject to a daily co-insurance payment (in year 2017 of $167.50 per day). Many (but not all) Medigap insurance policies will cover this daily co-insurance payment. Other part- time or intermittent custodial care coverage at home may be available but is usually very limited in scope.

How will I pay for custodial care services?

There are 3 principal ways to pay for custodial care:

1. Private payment (average annual nursing home costs in the greater New York area are currently around $15,000 per month or $180,000 per year)
2. Long Term Care Insurance
3. Medicaid

What is Long Term Care Insurance?

Long Term Care Insurance is a special kind of insurance designed to cover custodial care costs. It can be purchased to cover custodial care costs at home and/or in a nursing home.

What considerations should be taken into account when purchasing Long Term Care Insurance?

When purchasing a Long Term Care Insurance policy you should consider the following:

1. Cost – Premiums should remain steady; examine deductibility and waiting period features; inflation rider,
2. Length and amount of coverage – 3 years, 5 years or lifetime,
3. Type of coverage may be actual costs coverage or indemnity coverage in which a fixed sum is paid regardless of costs once coverage is triggered,
4. Cover both at-home and nursing home care (probably want significant home care benefit, if possible as indemnity coverage),
5. Require as few activities of daily living as possible in order to trigger coverage,
6. No prior hospitalization should be required,
7. Days spent in hospital awaiting placement should be covered,
8. Guaranteed renewability of policy, and limitations on premium increases,
9. Waiver of premiums during period of claim,
10. Respite care coverage,
11. Flexibility in applying benefits so that insured may choose among a nursing home, assisted living, adult day care center, or care at home,
12. Stability of Insurance Company, i.e., that it has been in the long term care industry for a long time with a good claims payment history (rated A+ by Best insurance rating service or others), and
13. May want to work with an insurance agent who can issue insurance for several different companies.

How do Hybrid/Combination Long Term Care and life insurance policies work?

Hybrid long term care and life insurance policies pay for services such as home care, assisted living room and board, and nursing home care services that are not covered by private health insurance or Medicare. These are policies that allow the owner to tap into their long term care insurance benefit if needed and/or provide a death benefit to their beneficiary if they do not eventually need long term care. Some combination policies provide a small death benefit no matter what, while others apply the portion of the benefit that has not been fully used to pay for long term care services as a benefit to your beneficiary upon your death.

Can I cancel a Hybrid/Combination Long Term Care and life insurance policy?

There's a money-back guarantee with some combination policies. The insurance company will return your premium if you decide you don't want the policy after a certain period of time. Before then, you can get a percentage of the premium back. Please discuss your individual policy with your insurance professional.

What is partnership insurance also known as Robert Wood Johnson Long Term Care Insurance?

New York State and several private insurance companies have entered into a joint venture to create a long term health care insurance product, which if purchased, would allow individuals with such insurance coverage to retain assets and still qualify for Medicaid after expiration of insurance coverage. This insurance is known as Robert Wood Johnson insurance or "Partnership Product" insurance.

Are there different kinds of Partnership Product Long Term Care Insurance?

Yes. There is coverage referred to as "Total Asset Protection" coverage or coverage referred to as "Dollar for Dollar Asset Protection" coverage. Total Asset Protection coverage offers unlimited asset protection when the policyholder exhausts the policy benefits and applies for Medicaid. Dollar for Dollar Asset protection coverage allows policyholders to establish asset protection based on the amount of benefits paid from the policy at the time the policy benefits are exhausted and the application for Medicaid is made.

Is it preferable to purchase Partnership Product Long Term Care Insurance rather than regular private Long Term Care Insurance?

It depends. Partnership Product insurance is not entirely portable in that it requires that you return to New York State in order to receive Medicaid coverage once the long term care insurance component has been exhausted. It also requires that your income be used toward the payment of the costs of your care (although your principal assets would remain protected). Ordinary private long term care insurance has no restrictions concerning geography, nor does it require that your income be used to pay for the custodial care after the insurance coverage period has lapsed, although Medicaid rules generally require it.

Determining which type of long term care insurance to purchase may be a function of age, as the older you get the more costly Partnership Product insurance tends to be due to the various requirements imposed by the State relative to regulation of this product. The decision may also be guided by whether or not the insured has significant retirement or other fixed income since this income would have to be paid to the long term care provider once the Medicaid component of the coverage becomes effective. However, Partnership Product insurance can be significantly less expensive for younger individuals and may, in certain circumstances, be the appropriate product of choice. Since Partnership Product coverage must be exhausted before Medicaid benefits may be obtained, it is important to consider whether the coverage provided will be sufficient to enable you to pay actual nursing home costs in your region.

PRESERVATION OF ASSETS/MEDICAID PLANNING

What is Medicaid?

Medicaid is a "needs based" government program established during President Johnson's administration to pay for the medical costs of the indigent population. As health care costs (particularly long term care custodial costs), have outpaced the rate of inflation, the middle class and upper middle class have also looked to the Medicaid program to pay for skyrocketing long term care expenses.

On February 8, 2006, President Bush signed into law legislation, entitled the Deficit Reduction Act of 2005 (the "DRA"), which made significant modifications to the then existing Medicaid laws. In addition, in April 2006, New York State passed legislation adopting the DRA and making other modifications to the laws implementing Medicaid in New York for applications filed beginning in August 2006. The Medical Assistance Program, which is the New York State plan for provision of Medicaid programs has also been significantly modified since 2011 by legislative enactment of the recommendations of Governor Cuomo's Medicaid Redesign Team and the adoption of expanded Medicaid under the Affordable Care Act. In 2020, Governor Cuomo empaneled a group known as the Medicaid Redesign Team II to make recommendations for additional savings in the Medical Assistance Program. A number of the team's recommendations were adopted by the New York legislature and signed by Governor Cuomo as part of the 2020-2021 New York State budget (Chapter 56 of the Laws of 2020) and will significantly affect long term care coverage.

Where relevant, the changes to the Medicaid laws as a result of the federal DRA legislation, the Affordable Care Act, and the recent New York State laws, as well as the possible effect of such changes on strategies for Medicaid qualification, are discussed in this section.

Asset protection and Medicaid planning are very complicated areas of law, particularly as a result of the DRA and legislation in New York State. It is highly recommended that you see an elder law attorney and/or other qualified professional before developing an appropriate estate plan.

Can you retain assets and income and still qualify for Medicaid?

Yes, subject to very stringent statutory limitations. The asset and income criteria for qualification for nursing home and home care Medicaid differ as do the Medicaid qualification requirements for a married couple as compared to a single person. Such qualification criteria are adjusted for inflation annually and are set forth below. (Please note figures set forth below are for the year 2020 only).

Medicaid in a Nursing Home

If married, the institutionalized spouse will qualify for Medicaid provided he or she has no more than $15,750 in resources and $50 per month of income, and provided that the Community Spouse (well spouse) does not have resources or income in addition to the following exemptions:

1. The family residence (no matter what the value) and provided the
2. Community spouse, or a minor or disabled child, resides there,
3. Between $74,820 and $128,640 of non-homestead assets,
4. $3,216 of monthly income which may consist of the community spouse's income and income from institutionalized spouse if the community spouse's income is insufficient,
5. Automobile of any value,
6. Life insurance not exceeding $1,500 in cash value, if designated as a burial fund,
7. Retirement assets except for required minimum distribution ("RMD"), which must be paid out in monthly installments, and
8. A reasonable amount for burial expenses pursuant to a prepaid irrevocable funeral contract plus an additional $1,500 to be deposited in a burial fund account.

If single, a Medicaid applicant may only retain:

1. A limited homestead exemption (potentially subject to a lien) if the institutionalized individual has subjective intent to remain home and provided the equity value of the residence does not exceed $893,000,
2. $15,750 of resources,
3. $50 monthly income,
4. No automobile,
5. Life insurance not exceeding $1,500 in cash value, if designated as a burial fund,
6. Retirement assets except for RMD which must be paid out in monthly installments, and
7. A reasonable amount for burial expenses pursuant to prepaid irrevocable funeral contract, a deed to a grave or family plot, plus additional $1,500 to be deposited in a burial fund account.

Medicaid at Home

If married, the spouse applying for Medicaid will qualify for Medicaid provided the married couple has no more than $23,100 of joint resources and $1,284 of monthly income, although the Medicaid applicant spouse may have more income and still qualify for Medicaid subject to certain limitations (see below) and provided that the spouse not applying for Medicaid does not have resources or income in addition to the following:

1. Family residence of any value,
2. $23,100 of joint resources,
3. $1,284 per month of income, with an additional $20 per month of unearned income,
4. Automobile,
5. Life insurance not exceeding $1,500 cash value, if designated as a burial fund,
6. Retirement assets except for RMD, which must be paid out in monthly installments, and
7. A reasonable amount for burial expenses pursuant to prepaid irrevocable funeral contract plus an additional $1,500 to be deposited in a burial fund account.

If a married person is applying for **Managed Long Term Care Services**, which is now required for most individuals in need of home care (see below), the Medicaid applicant spouse may retain $409 in monthly income and the Community Spouse (well spouse) can retain $3,216 in monthly income which may consist of the Community Spouse's income and income from spouse receiving Medicaid services if the Community Spouse's income is insufficient. In addition, the couple can retain the following resources:

1. The family residence (no matter what the value) and provided the Community Spouse, or a minor or disabled child resides there,

2. $15,750 in resources for the applying spouse and between $74,820 and $128,640 of non-homestead assets for the community spouse,

3. Automobile of any value,

4. Life insurance not exceeding $1,500 in cash value, if designated as a burial fund,

5. Retirement assets except for required minimum distribution ("RMD") which must be paid out in monthly installments and counted as income, and

6. A reasonable amount for burial expenses pursuant to a prepaid irrevocable funeral contract, a deed to a grave or family plot, plus an additional $1,500 to be deposited in a burial fund account.

If single, a Medicaid applicant may retain:

1. Family residence of any value provided equity value of residence does not exceed $893,000,

2. $15,750 of resources,

3. $875 per month of income, with an additional $20 per month of unearned income,

4. Automobile,

5. Life insurance not exceeding $1,500 cash value,

6. Retirement assets except for RMD, which must be paid out in monthly installments, and

7. A reasonable amount for burial expenses pursuant to a prepaid irrevocable funeral contract plus an additional $1,500 to be deposited in a burial fund account.

The New York State expansion of Medicaid in response to the Affordable Care Act includes coverage under Modified Adjusted Gross Income (MAGI) rules for persons under age 65 and not in receipt of Medicare. Coverage may be obtained for individuals with monthly income from 100% of federal poverty level, or $1,064 in 2020, up to 223% of federal poverty level, or $2,372, with no resource test. However, MAGI individuals cannot have surplus income.

Can an individual qualify for Medicaid even if his or her income exceeds Medicaid limits?

Yes. Although non-MAGI individuals applying for community Medicaid (Home Care Services) must pay their income in excess of the Medicaid allowance towards their cost of care, they can, as an alternative, join a community pooled trust and then place their surplus income into their own trust sub-account. Since the trust assets are an exempt resource, the funds are then sheltered from a Medicaid "spend down". Community pooled trusts are, by law, established and operated by a not-for-profit organization, and can only be used by disabled individuals; however, once the account is established, the funds can be used to pay for household bills in the name of the Medicaid applicant who is the trust beneficiary. In this way, Medicaid applicants may continue to use their income for their own benefit and still qualify for community Medicaid without a monthly spend down. Most trusts require a small monthly administrative fee and require that the funds be used for supplemental needs which include almost anything other than medical care, which is assumed to be covered by Medicaid. These trusts cannot be utilized by someone receiving nursing home Medicaid, and any funds remaining in a trust account after the beneficiary's death are retained by the not-for- profit organization. In addition, any amounts not spent for the sole benefit of the individual may be considered a transfer of assets and subject the individual to penalties, as described below after April 2021.

Please see Appendix F for a more detailed illustration of the use of community pooled trusts

What is Managed Long Term Care?

On Sept. 4, 2012, the federal Center for Medicare and Medicaid Services (CMS) approved a "1115 waiver" that allows New York State to require all dually eligible (for Medicare and Medicaid) adults now applying for or receiving long term care in the community to enroll in a Managed Long Term Care (MLTC) plan. MLTC providers are health care companies which either provide services directly or by contracting with licensed agencies.

The MLTC provider now controls access to, approves, and pays for all Medicaid home care services and other long term care services in the MLTC service package. This is the only way to obtain these services for adults who are dually eligible, unless they are exempt or excluded from MLTC.

Those already receiving Medicaid home care services will not have their level of care affected for 60 days after enrollment. After that, services may change, based on needs.

Who must enroll?

People must enroll if applying for the following services:

Personal Care/Home Attendant, Consumer Directed Personal Assistance, Adult Day Care, Certified Home Health Aides, and Private Duty Nursing.

How do I enroll in a plan to receive home care services?

In Westchester, new applicants for Medicaid home care must enroll in an MLTC program, which will perform the assessment to determine the level of services received. Once an applicant receives approval for Medicaid, he or she must first contact the New York Medicaid Choice Conflict-Free Evaluation and Enrollment Center (CFEEC) at 1-855-222-8350 to schedule an independent assessment to determine whether he or she is eligible for long term services. This evaluation will only determine whether the person is appropriate for long term care. It does note establish the hours or levels of care.

Once the initial assessment is completed the person must enroll in a MLTC program. A list of programs serving New York State is included in Appendix G. The MLTC provider will perform a second assessment, which will determine what type of care the person can receive and how many hours or home care are medically necessary.

Everyone is given the opportunity to choose an MLTC provider; however, if no choice is made, they will be auto-enrolled with a plan chosen by the coordinator.

As part of New York State laws of 2020, in order to qualify for MLTC services, an individual must need assistance with more than two Activities of Daily Living (ADLs) or more than one if the individual has also been diagnosed with dementia. Proposed regulations were introduced in 2020 implementing this new requirement, which will be implemented once the regulations are finalized (amending 18 NYCRR §505.14 and 18 §NYCRR 505.28).

Also, as part of the New York State laws of 2020, the Department of Health will be phasing in changes to the way that cases are assessed and on determinations of the quantity of care received. Currently the MLTC provider does the assessment to develop a plan of care; the new laws call for a single agency statewide to do all assessments. The new procedures are to be in place by October 2022.

It is advisable to consult an elder law attorney if you are seeking Medicaid home care services as the law is changing in this area.

Will Medicaid pay for Assisted Living?

Assisted Living combines residential and home care services. Most facilities are designed as an alternative to nursing home placement for people who do not require daily supervision by skilled nurses. Assisted living residences provide services that may include housing, meals, housekeeping, supervision, personal care, case management and home health services. There are many different varieties of Assisted Living which range from places offering basic room and board to residences that are designed for people with special needs.

Certain residences are licensed by New York State as Assisted Living Program (ALP) residences. ALP's accept Medicaid as full payment for residency. Your Social Security and other income must be remitted to the ALP on a monthly basis up to the level set by New York State, and residents are entitled to keep a personal needs allowance. In addition, a community pooled trust may be used for surplus income in excess of the New York State level.*

A number of Assisted Living residences are also licensed to provide enhanced care. Though Medicaid may not be available to pay for room and board, it may pay for home care and other community-based covered services in a non-Medicaid assisted living residence. Since there are many different types of residences which could call themselves "Assisted Living", you should always check with the admissions staff at the residence prior to signing any admission agreements.

In 2018, the New York State budget provided for a Special Needs Assisted Living Residence (SNALR) Voucher Demonstration Program, which provided vouchers of up to 75% of the average regional monthly cost of a SNALR to residents with Alzheimer's Disease or dementia and resided in a participating facility for more than 12 months. Individuals who had spent down their assets, and had not made any transfers in the past year, and were now eligible under certain income and resource rules, could apply. Only 200 vouchers were available statewide in 2018-2019. The program was not authorized in the 2020-2021 budget.

*A directory of Medicaid Assisted Living Program residences can be found at www.health.ny.gov/facilities/assisted_living/licensed_programs.htm

How many months of financial records must be submitted to the Department of Social Services for review with a Medicaid application?

The DRA legislation states that up to sixty (60) months of financial records can be reviewed for nursing home Medicaid. This review period is referred to as a "look-back period". If during the look-back period, the Department of Social Services ("DSS") discovers that an uncompensated transfer of assets (i.e., a gift) was made to a third party, DSS will apply a formula to determine how long an individual must wait before becoming eligible for nursing home Medicaid. Such waiting period is referred to as a "penalty period".

In 2021, for the first time in New York, there will be a thirty (30) month look-back for home care. The law became effective October 1, 2020, and is expected to apply to all Medicaid applications after April 1, 2021. The 30 month look-back will be phased in one month at a time, with the review period going back to October 1, 2020 until a full 30 months is reached. A penalty period of up to 30 months will be imposed for persons otherwise eligible for MLTC services.

May an individual transfer assets and still qualify for Medicaid and, if so, how is the "penalty period" calculated?

For Home Care Medicaid

Yes, until April 2021. Under the current law in New York State, gifts made during the look-back period for purposes of qualifying for home care (also referred to as community based) Medicaid are not subject to a penalty period, but rather an individual may qualify for home care Medicaid on the first day of the month after the gift is made, provided that at the time of the filing of the Medicaid application

the individual seeking home care Medicaid does not have more than $15,750 ($23,100 if the Medicaid Applicant is married) of resources nor more than $895 ($875 + $20 unearned income disregard) of monthly income in his or her single name. To the extent the individual has income exceeding the $895 monthly income limit, such excess must either be used to pay the home health care agency providing services or be paid to a pooled income charitable trust which trust can use such income to pay the ongoing household and other expenses of the homecare Medicaid applicant or to pay the premiums of a private health insurance plan.

Effective April 1, 2021, individuals applying for MLTC services must submit financial documentation back to October 1, 2020, and all subsequent applications will require financial documentation back to October 1, 2020, until a full 30 months is reached. Most transfers of assets will result in a penalty period (i.e., delay in qualification for Medicaid) equal to one month for every $12,805 transferred. Said amount of $12,805 is fixed by New York State as the average monthly nursing home cost in Westchester County during the year 2020 and is revised annually. (The 2020 rate amount in New York City is $12,844.) The maximum penalty period for home care Medicaid is 30 months.

For Nursing Home Medicaid

Yes. There is, however, a penalty period resulting from a gift made when the donor of the gift will be applying for nursing home Medicaid. If applying for nursing home Medicaid during the applicable look-back period, most transfers of assets will result in a penalty period (i.e., delay in qualification for Medicaid) equal to one month for every $12,805 transferred. Said amount of $12,805 is fixed by New York State as the average monthly nursing home cost in Westchester County during the year 2020 and is revised annually. (The 2020 rate amount in New York City is $12,844.)

For both home care cases (after April 1, 2021) and nursing home cases, a penalty period is computed by taking the amount transferred during the look-back period and dividing such transferred sum by the regional rate New York State mandates as the average monthly nursing home cost in the area in which the donor of the gift resides (i.e., $12,805 in Westchester or $12,844 in New York City). The quotient of such formula is the penalty period in that it determines how many months an individual applying for Medicaid must wait until eligible.

By way of example, in Westchester County, New York State has fixed $12,805 as the average monthly nursing home cost in 2020. Thus, if the donor gifted the sum

of $128,050 during the look-back period, such a transfer would result in a penalty period of ten months ($126,360 ÷ $12,636 = 10 months). The determination of the commencement date of the penalty period is further discussed below.

When does the penalty period begin?

The penalty period to receive nursing home or MLTC Medicaid commences on the date on which the individual is "otherwise eligible" for Medicaid and would be receiving care services based on a Medicaid application for such care but for the application of the penalty period.

The legislation indicates that in order to start the penalty period running, all of the following must occur:

1. The Medicaid applicant must have less than $15,750 in non-exempt resources; and

2. The Medicaid applicant must be in a nursing home or receiving home care services; and

3. The Medicaid applicant must have formally applied for Medicaid benefits.

Applying the current law to our example would have the following result. If the Medicaid applicant transferred the sum of $128,050 in November 2018, and was admitted to a nursing home and also submitted a Medicaid application in November 2020, the look-back period (which extends back 60 months prior to the date of the application) would capture the transfer made 24 months before the date of the application and the resulting penalty period would cause the Medicaid applicant not to be eligible for Medicaid nursing home coverage until August 2021.

August 2021 becomes the Medicaid eligibility or "pick-up" date because the commencement of the 10 month penalty period would start to run in December 2020 as that is the first month after the transfer in which the Medicaid applicant had: 1) no more than $15,750 in his or her name, 2) entered the nursing home and 3) submitted the Medicaid application.

During the period from the date of filing the Medicaid application and entering the nursing home and being found "otherwise eligible" in November 2020 and until the expiration of the penalty period in August 2021, the Medicaid applicant would have to pay privately for his or her stay at the nursing home, using funds that he or she had previously gifted to others in November 2018.

For Medicaid applicants needing home care, any transfers after October 1, 2020 can result in a penalty being assessed. For example, if the applicant transfers the sum of $128,050 in November 2020 and submits a Medicaid application seeking Managed Long Term Care home care services in November 2022, the look-back period goes back to October 1, 2020, a period of 25 months, and would capture the transfer made 24 months prior to the application and the transfer would cause the applicant to be ineligible for the requested Medicaid coverage for a period of 10 months, as calculated above. The applicant would not be able to receive home care services until August 31, 2023. As in the example above, the Medicaid applicant would have to pay privately for his or her care during this 10 month period, using funds that he or she had previously gifted.

Thus, in order to avoid the spend-down of previously transferred funds during the penalty period, it may be necessary for a Medicaid applicant to wait 2.5 or 5 years from the date of transfer until applying and becoming eligible for Medicaid.

Transfers of assets must be carefully calculated to assure that elderly individuals are not deprived of the funds they need to provide for their care during any resulting penalty period or Medicaid disqualification. No individual should transfer funds for Medicaid planning purposes without consulting with an experienced elder care attorney.

Can one spouse qualify for Medicaid even if the resources and/or income of the other spouse exceeds Medicaid limits?

Yes, by the practice of "Spousal Refusal." Current New York State law provides that Medicaid may not be denied to an ill spouse (the applicant spouse) even if the other spouse (the well spouse) has excess resources and/or income if the well spouse refuses to contribute such excess resources to the cost of the care of the ill spouse. In such a case, the refusing spouse must disclose the amount of assets in his or her possession and the applicant spouse must assign his or her obligation of support from the refusing spouse to the State of New York. Spousal Refusal may result in the State of New York or local Department of Social Services suing the refusing spouse for the support the State has expended on behalf of the applicant spouse. (However, the State can only sue the refusing spouse for services provided at the Medicaid rate which is often considerably less than the private pay rate which the refusing spouse would otherwise be paying).

Are there assets which can be transferred which will not cause a transfer penalty period delaying Medicaid qualification?

Yes. The transfer of an asset is not subject to the Medicaid penalty period if:

1. The asset is transferred to the Community Spouse (however, a subsequent transfer by the Community Spouse may result in additional transfer penalties),

2. The asset is transferred to a blind or disabled child,

3. The asset is transferred to a trust established solely for the benefit of any disabled individual,

4. The asset is the Medicaid applicant's residence and the residence is transferred to a sibling of the Medicaid applicant with an equity interest in the house,

5. The asset is the Medicaid applicant's residence and the residence is transferred to a child of the Medicaid applicant who is blind, disabled or less than 21 years of age, or

6. The asset is the Medicaid applicant's residence and the residence is transferred to a child of the Medicaid applicant who has resided with and cared for the Medicaid applicant for two years prior to institutionalization, which care allowed the Medicaid applicant to remain at home ("Caretaker Child" exception).

Will ownership of retirement assets by the Medicaid applicant disqualify such individual from Medicaid eligibility?

The answer is "NO" irrespective of the value of the retirement account provided that the retirement account (e.g., IRA, 401(k), 403b or other retirement plan) is in periodic payment status.

Thus, if the Medicaid applicant is taking his minimum distribution amount from his IRA or other retirement account on a monthly basis (as opposed to an annual basis), such retirement account will not be counted for Medicaid purposes and the Medicaid applicant can still qualify for Medicaid. However, although the principal portion of the retirement account is unavailable, the minimum distribution amount, which is deemed to be an income stream, must still be paid to the nursing home or home health care agency or pooled income charitable trust while the Medicaid applicant is receiving Medicaid benefits.

In addition, the retirement account of the community spouse, no matter its value, is also an unavailable resource because it forms part of the community spouse resource allowance. The community spouse's retirement account need not be in periodic payment status and is still a fully unavailable resource even if the amount of the account exceeds the community spouse resource allowance.

Can a Medicaid applicant's home be protected upon entry into a nursing home?

It is possible for the Medicaid applicant to sign a statement of intent to return home and the execution of such a statement will cause the residence to become an unavailable resource. However, if the Medicaid applicant enters a nursing home and becomes permanently absent from the premises, New York State, by its local County Department of Social Services, can place a lien on the premises, which lien could be satisfied out of the proceeds from the eventual sale of the residence. The payback of the lien is at the Medicaid rate rather than the private pay rate.

A Medicaid applicant's ownership of a residence with an equity interest in excess of $893,000 will make that residence an available resource that cannot be sheltered by the execution of a statement of intent to return home. However, any residence, no matter its value, could still be protected if occupied by a spouse or minor or disabled child or if transferred to such individuals or to a caretaker child, or to a sibling with an equity interest as described above, or by encumbering the residence with a mortgage or other debt to reduce its equity interest below $893,000.

What are the methods for transfers of assets?

1. Outright gifts,
2. Life Estate Deed,
3. Transfers in Trust, and
4. Annuities, mortgages, promissory notes, personal service contracts.

What are the consequences of making an outright gift for Medicaid qualification purposes?

You lose control of the asset by giving full control of the asset to another. In addition, depending upon the value of the asset, there may be gift tax considerations which

must be evaluated. Finally, if you are transferring appreciated property (e.g., a residence or securities), the recipient of the property receives your original low cost tax basis, meaning that upon a subsequent sale of the property by the recipient, there may be a significant capital gains tax to pay.

What are the consequences of using a life estate deed for Medicaid qualification purposes?

A transfer of real property subject to the transferor's retention of a "life interest" in the property may be an effective way of sheltering an asset for Medicaid qualification. If properly drawn, it avoids the applicability of the federal gift tax law. In addition, use of a life estate deed allows the transferor to shorten the transfer penalty period, since the value of the asset transferred does not include the actuarial value of the transferor's life interest in the property.

For example, a 75 year old Westchester resident transferring a $300,000 property in July 2020 is only deemed to have transferred $280,914 for Medicaid transfer purposes and thus would qualify for Medicaid in 21.94 months ($280,914 ÷ $12,805 = 21.94 months) rather than the 23.43 month period that would have applied if an outright transfer had been made ($300,000 ÷ $12,805 = 23.43 months).

In addition, if the property is not sold until after the death of the transferor, the remaindermen (i.e., the individuals referenced in the deed as receiving the property at the life tenant's death) will inherit the property at its fair market value as of the date of death. The appreciated property will have a higher cost basis (not the original purchase price cost basis) and should be able to be sold shortly after the transferor's death with negligible, if any, capital gains.

Selling the property during a transferor's lifetime may create unintended tax consequences and may trigger undesirable additional Medicaid eligibility problems.

If the property is sold during the transferor's lifetime there will be a capital gains tax due on any portion of the gain which relates to the remainder interest in the property as only the life interest is eligible for the $250,000 per person lifetime capital gains exemption. In addition, if the sale occurs during the transferor's life, such a sale may cause significant asset exposure in that the portion of the sales proceeds allocable to the life estate interest must be returned to the life tenant and again becomes an exposed resource which would be subject to new look-back and penalty periods and then have to be retransferred in order to be protected, which further protection would only occur if such new look-back and penalty periods had expired before the need for Medicaid.

Thus, if using a life estate deed, there should be a commitment that the property not be sold during the life estate owner's lifetime.

The advantages of using a life estate to shorten the transfer penalty period is less important now that New York State has formally implemented the DRA legislation. The advantages are largely lost because the commencement of the Medicaid penalty period for all asset transfers which occur within the 30 or 60 month look-back period, including life estate transfers, commence when the Medicaid applicant applies for Medicaid and is otherwise eligible for benefits. Thus, a full five years has to elapse from the date of the transfer before a life estate transfer, like any other transfer, is not considered as a countable resource for Medicaid eligibility purposes.

However, it is still possible to do planning by having an individual purchase for value a life estate interest in the residence of another. If the purchaser of the life estate resides in such residence for at least a one year period following the date of purchase, then the funds used to purchase the life estate are an exempt resource and not countable when such individual applies for Medicaid. Thus, if a Medicaid Applicant is "over resourced" (i.e., has assets exceeding Medicaid eligibility limits) but uses such assets to purchase an interest in the residence of another and then resides in such residence for at least one year thereafter, they will obtain Medicaid eligibility in just one year's time which is far more quickly than if they had made a direct transfer of the excess assets to such individual which would then be subject to the look back and penalty period computations previously mentioned.

What are the consequences of transferring assets to an Irrevocable Trust for purposes of Medicaid qualification?

A properly drafted irrevocable trust will minimize gift and capital gains tax problems, whether the property is sold while the grantor is alive, or after the grantor's death, and allows the proceeds from the sale of property to remain in the trust and be protected. Generally, the income tax treatment of an irrevocable trust is the same as if the grantor of the trust had continued to own the asset in his or her individual name. An irrevocable trust also has the advantage of allowing the grantor to place a variety of assets, in addition to the real estate, into the ownership of the trust.

The irrevocable trust further allows the grantor to retain certain control of the assets contributed because the grantor can continue to receive the income generated by the trust assets and still protect the principal asset (i.e., corpus of the trust) and still qualify for Medicaid. (Of course, the principal assets contributed to the irrevocable trust cannot be directly returned to the grantor). In addition, by having the trust document retain for the grantor a "power of appointment", the grantor will be able to change the identity of the beneficiaries of the trust.

Will the S.T.A.R., Veteran's and/or Senior's Exemption still apply to real property transferred to an Irrevocable Trust?

Yes, to the extent the grantor still retains a lifetime use and occupancy of the real property.

Can assets still be protected even after an individual has been admitted to a nursing home?

Yes, under current law, it is possible to protect assets even after an individual has been admitted to a nursing home. The percentage of the assets that may be protected, however, will not be as significant as if advance planning had been done. Gifts made by the Medicaid applicant in exchange for an annuity, loans extended in return for a promissory note, or the establishment of a personal services contract where the Medicaid application enters into a formal contract with others (including family members) to have personal or financial care services performed are possible asset savings strategies which can be utilized even after entry to the nursing home. These strategies are further discussed herein.

Can the purchase of an annuity by the Medicaid applicant result in Medicaid qualification?

Sums used to purchase an irrevocable and actuarially sound annuity may, in certain limited circumstances, serve to shelter assets for Medicaid qualification. However, under the DRA legislation, the State of New York must be named as a beneficiary of the annuity to reimburse the State for care it funded through Medicaid. Moreover, the income paid out by the annuity must be paid towards the cost of care or sheltered in a charitable pooled income trust. New York State does not need to be named a primary beneficiary if the Medicaid applicant has a spouse or minor or disabled child.

Can the making of a loan by a Medicaid applicant result in Medicaid eligibility?

Loans, mortgages and promissory notes may be used in a similar manner to the use of an annuity and New York State does not have to be named as a beneficiary of the remainder. However, the loan, mortgage or note must be actuarially sound, nonnegotiable and non-assignable, made in equal monthly installments over the term of the loan and cannot be canceled because of the death of the lender meaning that the Medicaid applicant's estate may be responsible to pay back the State of New York for health services rendered to the Medicaid applicant.

An example of the use of an annuity or promissory note loan to protect assets for Medicaid eligibility is as follows:

An 80 year old parent owns $614,640 in assets. The parent gifts one-half of that amount (i.e., $307,320) to the child causing a penalty period delaying eligibility for the parent to receive Medicaid for 24 months (i.e., $307,320 ÷ $12,805 regional rate = 24 months). The penalty period does not begin to run until the parent makes a Medicaid application and is otherwise eligible for Medicaid but for the gift which was made.

The parent uses the other $307,320 to purchase an annuity or makes a loan for a term which cannot exceed her life expectancy (an 80 year old woman has life expectancy of 9.74 years or 116.88 months). Based on a loan or annuity term of 2 years (i.e., equal to the 24 month penalty period) and an interest rate of 3.0%, payments of $13,208.99 would have to be made on the annuity or loan to the parent which, in turn, would have to be paid for her care during said 24 month penalty period.

If her health care costs $15,000 per month privately and parent has Social Security and pension of $1,750 per month and the annuity or promissory note is producing $13,208.99 per month, then the parent has monthly income of $14,958.99 to pay toward the $15,000 per month health care cost leaving a shortfall of $41.01 per month which could be paid from the $307,320 gifted to the child which over the 24 month penalty period would reduce said gift of $307,320 by $984.24 ($41.01 x 24 months).

Once the 24 month penalty period has expired, the parent is on Medicaid and no further payments from the child of the gifted funds are required. Thus, parent has safely transferred to child $296,840.09 (i.e., $614,840 - $317,015.67 promissory note payments including interest - $984.24. = $296,840.09) in order to qualify for Medicaid.

In addition, if the parent dies prior to the expiration of an annuity, the balance of the annuity first must be used to pay back Medicaid expended by New York State as primary beneficiary, at the Medicaid rate, but the balance, if any could be paid to the child as secondary beneficiary. Similarly, if the parent dies prior to expiration of promissory note, the estate of the parent, as owner of the note, must first pay back Medicaid before distributing further to the surviving family. However, with a promissory note, generally, no Medicaid will have been paid because of the penalty period.

An asset preservation instrument called the Grantor Retained Annuity Trust (GRAT) has been used in New York with mixed results. A GRAT is similar to a private annuity and provides for the Trustee to make periodic payments back to the Grantor, similar to the promissory note and annuities described above. It has been used with some success in several parts of the state; however, there was a 2007 case where the entire trust was determined to be available to pay for nursing home care. In 2008, the State Department of Health determined that, since a GRAT was a trust, it could be invaded to the extent that any or all of it could be used for health care costs. Use of a GRAT in connection with Medicaid planning should only be undertaken under the supervision of an elder law attorney thoroughly familiar with the current treatment of GRATs in the Medicaid applicant's county.

Can a personal services contract be used to obtain Medicaid benefits?

Existing law has held that payment for personal or financial services pursuant to a written personal services contract is not a transfer of assets. To be recognized, such care agreements must be in writing, must be prospective in nature and the compensation must be reasonable. Such contracts can pay a lump sum to the service provider for anticipated services to be provided over the actuarial life of the Medicaid applicant. Family members can certainly be the providers of such services. Good record-keeping, with payments being made "on the books" as income taxable to the recipient with appropriate deductions for worker's compensation, etc. should be kept.

An example of the use of a personal services contract for Medicaid eligibility is as follows:

Daughter/Caregiver works full time and assists her 80 year old mother who has an actuarial life expectancy of 9.74 years. Daughter provides to her mother five (5) hours per week of financial and health care management at the rate of $30 per hour, and ten (10) hours per week of personal care at the rate of $25. In this example, the caregiver earns $150 per week or $7,800 annually for financial and health care management services and $250 per week or $13,000 per year for personal care services. For the 9.74 years of the estimated life of the contract, $75,972 represents the value of the contract's managerial component and $126,620 represents the value of the contract's personal service component. The entire contract is valued at $202,592.

NYSDOH has indicated that a personal services contract will be considered a transfer of assets unless it provides for a return of prepaid funds if the caregiver is unable to continue services or if the Medicaid recipient dies before his or her calculated life expectancy.

Also, the same directive, issued in 2007, states that no credit will be given for services that are provided as part of the Nursing Home rate. This makes it very difficult to use a personal services contract for a nursing home resident.

However, a personal services contract can properly be used while a person is residing at home and can provide for compensation to family members who are acting as caregivers. Caregivers should also be aware that amounts received from a personal services contract are subject to income tax.

Can Medicaid take my assets after I die?

If you received Medicaid during your lifetime, a claim may be made against your estate for the amount of benefits you received after age 55. If your estate is greater than the total of benefits received, Medicaid's total recovery is limited to the amount of benefits provided; on the other hand, if your estate is less than the total of benefits received, the claim is limited to the funds in your estate. Funeral expenses, taxes, administrative expenses of the estate, including legal fees, and commissions earned by the estate fiduciary could all be paid first, and will reduce the amount available to pay this claim.

In addition, recovery is deferred, but not exempted, if there is a surviving spouse, a blind or disabled child of any age, or child under age twenty-one. If the sole asset of the estate is a homestead, Medicaid recovery is also deferred if the home is occupied by a "caretaker" child who resided in the home for two years prior to the institutionalization of the decedent or a sibling of the decedent who resided in the home for at least one year prior to the to the institutionalization of the decedent.

Estate claims are limited to probate assets, and do not include jointly-held bank and investment accounts, retained life estates created in property, and/or jointly-held real estate.

In the case of a spouse who has refused to provide support (as discussed), a claim may be made against that spouse's estate to the extent that the refusing spouse had assets over the Medicaid allowance when benefits were being provided.

Information and documentation concerning the Medicaid applicant and his or her spouse must be gathered together and accompany the submission of a Medicaid Application. A checklist detailing the information required to complete the Medicaid application and a sample Medicaid application is set forth as Appendix H and Appendix I, respectively, in this booklet.

SUPPLEMENTAL SECURITY INCOME (SSI) vs. SOCIAL SECURITY DISABILITY INSURANCE (SSDI)

What Are These Benefits and How Do They Differ?

Several benefits programs provide financial assistance to seniors and persons living with disabilities. SSI and SSDI are two of the most common federal programs from the Social Security Administration.

What is SSI?

Supplemental Security Income (SSI) provides minimum basic financial assistance to older adults and persons with disabilities (regardless of age) with very limited income and resources. Federal SSI benefits from the Social Security Administration are often supplemented by state programs.

What is SSDI?

Social Security Disability Insurance (SSDI) supports individuals who are disabled and have a qualifying work history, either through their own employment or a family member (spouse/parent).

What is the difference between SSI and SSDI?

The major difference is that SSI determination is based on age/disability and limited income and resources, whereas SSDI determination is based on disability and work credits.

In addition, in most states, an SSI recipient will automatically qualify for Medicaid. A person with SSDI will automatically qualify for Medicare after 24 months of receiving disability payments (individuals with amyotrophic lateral sclerosis [ALS] are eligible for Medicare immediately).

COMPARISON OF SSI AND SSDI

Factor	SSI	SSDI
Eligibility based on	Age (65+) OR blindness (any age) OR disability (any age) AND limited/ no income and resources	Disability AND sufficient work credits through own/ family employment
When benefits begin	1st full month after the date the claim was filed or, if later, the date found eligible for SSI	6th full month of disability; 6-month period begins with the first full month after the date SSA decides the disability began
Eligible Individual benefit (monthly)	$783 (as of January. 2020)	Non-Blind: $1,229 Blind: $2,040 (as of Jan. 2019) Trial Work Period: $880
Eligible Couple benefit (monthly)	$1,175	$2,861 in 2019 (based on work history)
Health insurance	Automatically qualifies for Medicaid upon receipt of SSI (in most states)	Automatically qualifies for Medicare after a 24-month waiting period from time benefits begin (no waiting period for persons with ALS)

Can I have both SSI and SSDI?

Yes, it is possible that if you have both limited income/resources and a work history, you can qualify for both benefits.

How do I apply for SSI or SSDI?

You can apply for SSI online only if you are an adult with a disability. SSI applications are not available online for people applying for a child under age 18 with a disability or a non-disabled senior aged 65+. These individuals must visit their local Social Security office or call 1-800-772-1213 (TTY 1-800-325-0778) between 7 a.m. – 7 p.m., Monday through Friday.

You can apply for SSDI benefits online at any age. You also can apply by calling Social Security at the number above or at your local office.

How does Social Security define disability?

Social Security uses a strict definition of disability that relates to your ability to perform work and the projected length of your disability. It requires that you submit medical records to support your application. If you have a short-term or partial disability, you are not eligible for SSI or SSDI.

How long does it take for the application to be processed?

Social Security Administration's website states that you will be notified of a decision within 3 to 5 months of the application date. However, the time period for approval varies.

People who have severe disabilities that fall under Social Security's Compassionate Allowances (CAL) classification will receive expedited review of their SSI/SSDI applications. There is no special application form or process for CAL applicants.

If I wait a long time to receive benefits will I receive back payments?

Back pay refers to Social Security Disability benefits that you would have received had your claim been immediately approved. If there is a delay in receipt of benefits, you may be entitled to a lump sum payment of back pay after you are approved for SSDI or SSI benefits. Back pay covers all of the months in which you should have been receiving benefits. For SSDI you are entitled to receive back pay if you wait to receive benefits for more than five (5) months for SSDI. SSDI back payments arrive as a single lump sum payment. This is because disability claimants who have been approved to receive SSDI benefits are subject to a five-month waiting period before Social Security owes the claimant disability benefits.

SSI recipients can receive back pay if they wait for just one month, but most back pay will not come to people on SSI in one check. It will often be split into three separate payments, each one arriving 6 months after the previous.

If I am 62 and disabled, does it make sense to apply for SSDI or early Social Security benefits?

You can apply for early Social Security retirement benefits beginning at age 62. However, taking retirement early reduces the amount of your benefit for the rest of your life. But if you get SSDI, that benefit amount would be equal to your full Social Security retirement age benefit.

In most circumstances, if you are qualified for SSDI, it makes sense for you to apply for that benefit instead of drawing early Social Security. But if you decide to take early retirement (perhaps you need the income while waiting to hear about your SSDI application), you can apply for retroactive SSDI. If you are found to have met the disability requirements before you began to receive early retirement, you would be entitled to retroactive benefits equal to the difference between your early retirement payment and what you were entitled to for SSDI.

However, if Social Security determines that your disability did not begin until after you received early retirement, you won't receive any retroactive payments. Instead, your Social Security payments will simply convert to your SSDI benefit amount. Once you reach retirement age, your full retirement benefits will be reduced based on how many months you received early retirement (called the "reduction factor").

What if I start earning countable income while on SSI?

The monthly payment amount is reduced by subtracting monthly countable income. Countable monthly income is anything you receive during a calendar month and can use to meet your needs for food or shelter. It may be in cash or in kind. In-kind income is not cash; it is food or shelter, or something you can use to get food or shelter. In the case of an eligible individual with an eligible spouse, the amount payable is further divided equally between the two spouses. Some States supplement SSI benefits.

Where can I find additional information about SSI?

Additional information can be found online on the Social Security Administration website at: **https://www.ssa.gov/OACT/COLA/SSI.html**

ELDER ABUSE

This chapter was written for *Elder Law Q & A: An Introduction to Aging Issues and Planning for the Future* by the Harry and Jeanette Weinberg Center for Elder Justice at the Hebrew Home at Riverdale.

What is elder abuse?

According to a 2016 report issued by the Centers for Disease Control†, elder abuse is an intentional act or failure to act by a caregiver or another person in a relationship involving an expectation of trust that causes or creates a risk of harm to an older adult.

†Hall, JE, Karch, DL, Crosby, AE. Elder Abuse Surveillance: Uniform Definitions and Recommended Core Data Elements For Use In Elder Abuse Surveillance, Version 1.0. Atlanta (GA): National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 2016.

What are some common forms of elder abuse?

Physical abuse, psychological and emotional abuse, sexual abuse and economic or financial exploitation are all forms of elder abuse. Abuse may be subtle; even inaction can sometimes be abusive. Abuse is generally a pattern repeated over time, and is rarely a one-time occurrence. It is important for older adults to know their legal rights to prevent or stop abuse.

It is estimated that one out of ten Americans over sixty living in the community has experienced some form of elder abuse. In New York State, only one in twenty four cases of elder abuse is reported to social services or law enforcement professionals.

Who commits elder abuse?

Among reported cases, a family member, including adult children and spouses, was often the person committing the elder abuse.

While any family member could be abusive or neglectful, adult children are the most common perpetrators. Abusers often live with the parent they are mistreating and frequently depend on that parent financially and emotionally. Other abusive family members may be spouses, adult grandchildren or other relatives, such as nieces, nephews, cousins, stepchildren or step-grandchildren or siblings. While there is no

"typical" abuser profile, many abusers often have drug addictions, substance abuse problems, serious and untreated mental health issues and a past history of violence.

Abusers can also be trusted professionals. In a 2011 study by the MetLife Mature Market Institute*, they found that a large percentage of elder financial abuse cases involved close associates of the victim – families, friends, caregivers and neighbors – as the perpetrator of the abuse, accounting collectively for 34% of the reported cases. Exploitation within the business sector, coupled with Medicare and Medicaid fraud, accounted for a combined 16% of reported cases. The MetLife study estimated that$2.9 billion was taken from seniors, while a more recent Senior Vulnerability Survey** estimated a much higher figure – over $30 billion.

*The MetLife Study of Elder Financial Abuse: Crimes of Occasion, Desperation and Predation against America's Elders, June 2011 **The True Link Report on Elder Financial Abuse 2015

What are some instances of Elder Abuse and neglect?

Every elder abuse situation has its own unique and distinct set of circumstances. Some examples of abuse are:

A son, in order to punish his 76 year old father, takes his dentures to limit what he can eat.

- **Physical Abuse** is the intentional use of physical force that results in acute or chronic illness, bodily injury, physical pain, functional impairment, distress, or death. Physical abuse may include but is not limited to such acts of violence as striking (with or without an object or weapon), hitting, beating, scratching, biting, choking, suffocation, pushing, shoving, shaking, slapping, kicking, stomping, pinching, and burning. In addition, inappropriate use of medications and physical restraints, pinning in place, arm twisting, hair pulling, force-feeding, and physical punishment of any kind also are examples of physical abuse.

A daughter intentionally isolates her 67 year old mother from friends and family by keeping her from having any visitors or leaving the home.

- **Psychological and Emotional Abuse** is verbal or nonverbal behavior that results in the infliction of anguish, mental pain, fear, or distress, that is perpetrated by a caregiver or other person who stands in a trust relationship to the elder. May include any of the following: humiliation/disrespect, threats, harassment and isolation/coercive control.

A nephew makes demeaning remarks about his 85 year old aunt's intimate body parts.

- **Sexual abuse** is forced and/or unwanted sexual interaction of any kind with an older adult. This includes non-contact acts of a sexual nature such as forcing a victim to view pornographic materials, photographing an elder for sexual gratification, voyeurism and verbal or behavioral sexual harassment.

A granddaughter uses the power of attorney she has gotten for her 90 year old grandfather to take $1,000 from his checking account to buy herself a new diamond ring without her grandfather's permission or knowledge.

- **Financial Abuse or Exploitation** is the illegal, unauthorized, or improper use of an older individual's resources by a caregiver or other person in a trusting relationship, for the benefit of someone other than the older individual. This includes, but is not limited to, depriving an older individual of rightful access to, information about, or use of personal benefits, resources, belongings, or assets.

A sister, knowing that her 75 year old brother is unable to care for himself and angry at the burden placed on her, often is too busy and fails to give her brother his medicine.

- **Neglect** is failure by a caregiver or other person in a trust relationship to protect an elder from harm or the failure to meet needs for essential medical care, nutrition, hydration, hygiene, clothing, basic activities of daily living or shelter, which results in a serious risk of compromised health and/or safety.

What should I do if I suspect elder abuse?

- If an emergency, call 911
- Talk to someone you trust
- Get help from a social service agency
- Call an Elder Law attorney
- Go to Court

If an emergency, call 911

In an emergency situation, call 911 and get immediate help. In a non-emergency, contact your local police department or another community resource listed below. Many police departments now have community police officers and domestic violence officers specially trained in dealing with abusive situations who can arrange for regular wellness checks and connect the older adult to other community resources.

Talk to someone you trust

If the mistreatment is kept a secret and nothing is done, chances are the abuse or neglect will worsen. No matter what happened in the past, it is never acceptable for someone to hurt or mistreat an older person. Speaking up about the abuse increases the likelihood of finding someone who can help provide workable and desirable alternatives. A safety plan should be developed to fit the particular circumstances of each victim.

Whom do I contact to report elder abuse in Westchester County?

- Adult Protective Services – (914) 995-2259
- Westchester Department of Senior Programs and Services –(914) 813-6436
- Victims Assistance Services – (914) 345-9111 or (914) 345-3113
- Westchester District Attorney's Office (Elder Abuse Unit) –(914) 995-3414
- Pace Women's Justice Center – (914) 287-0739
- Westchester County Office for Women Helpline – (914) 995-5972

For Professionals Only

- The Harry and Jeanette Weinberg Center for Elder Justice at the Hebrew Home at Riverdale (800) 56-SENIOR (567-3646)

National Resources

United States Department of Justice Elder Justice Initiative.
https://www.justice.gov/elderjustice

The mission of the Elder Justice Initiative is to support and coordinate the Department's enforcement and programmatic efforts to combat elder abuse, neglect and financial fraud and scams that target our nation's seniors. The website is a comprehensive resource for both professionals and community members about national initiatives and local resources.

National Center on Elder Abuse
Phone: (855) 500-3537; **https://ncea.acl.gov**

This site provides guidance on responding to elder abuse – who to call if abuse is suspected, what to expect, prevention methods, and what can be done to stop elder abuse. Website includes a listing of statewide toll free telephone numbers to call to report elder abuse.

Call an Elder Law Attorney

An elder law attorney can help with obtaining a guardianship for the personal needs and property management of an older person, provide advice on the older person's legal rights and available remedies, or even help set up a financial plan or financial instruments to preserve/protect the older person's assets. One way to contact an elder law attorney is through references from friends, family or trusted acquaintances.

Online resources may also aid in the search for an elder law attorney:
http://lawyers.findlaw.com/lawyer/practicestate/Elder-Law/New-York
http://www.seniorlaw.com/elder-law-attorneys-on-the-web/

Legal Interventions

Older adults can take action to stop the abuse by obtaining a Family Court Civil Order of Protection against an abuser. In New York State, Family Court has jurisdiction where the parties are or have been married to, have a child in common, are or were in an intimate (can be non-sexual) relationship or are related to by blood or marriage. A civil lawyer can help discuss this option.

If abuse is financial, there are additional avenues of assistance to pursue.

Some examples of financial exploitation are where an older person is being pressured to: sign a document that he or she doesn't understand, distribute his or her money or belongings to someone he or she did not choose, add an unwanted name to his or her deed, give up control of his or her personal business or health care decisions, change his or her will, or add an unwanted beneficiary to his or her Will or pension accounts. It is important to be aware of the risks of joint bank accounts and credit card accounts, co-signing a loan or designating someone as power of attorney.

Some organizations and resources that can provide counseling or assistance for cases of financial exploitation include:

- Westchester County Department of Consumer Protection (Consumer Assistance) (914) 995-2155; **https://consumer.westchestergov.com/**
- Community Capital New York (914) 747-8020; **https://www.communitycapitalny.org**
- New York State Office of the Attorney General (914) 422-8755; **ag.ny.gov**
- Go Direct (for direct deposit of Social Security checks) (800) 333-1795; **www.GoDirect.org**
- Women's Institute for a Secure Retirement https://www.**wiserwomen.org**

The Harry and Jeanette Weinberg Center for Elder Justice at the Hebrew Home at Riverdale (a program of RiverSpring Health)

Established in 2005, the Weinberg Center is the nation's first shelter for elder abuse victims, serving eligible individuals 60 years and older. The Weinberg Center provides short-term housing, comprehensive healthcare, legal advocacy and therapeutic services.

Intervention

Professional referrals provide prompt access to the Weinberg Center team for consultation and assessment to determine shelter eligibility. Once admitted, each client receives individualized and comprehensive coordinated care provided by the Hebrew Home's medical and professional staff.

The Weinberg Center's multidisciplinary team develops a holistic and trauma informed action plan based on each client's particular circumstances and goals. Civil legal services are a cornerstone of our work, and can include obtaining Orders of Protection, representing clients in Housing Court or advocating in a guardianship proceeding.

Outreach and Training

The Weinberg Center offers a wide range of training and community outreach programs to increase professional and public awareness about the signs and symptoms of elder abuse and neglect. If you are interested in setting up a training or community outreach program, please call (718) 581-1472.

National Model

The Weinberg Center continues to foster replications of the shelter model around the country. The SPRiNG Alliance (Shelter Partners: Regional, National, Global.) is a network of elder abuse shelters with close working relationships, shared expertise, common standards of excellence and a vibrant community of support. Learn more at spring-alliance.org.

Assessment

The Weinberg Center has developed an elder abuse assessment tool to screen for at-risk and abused older adults. The screen is available to all long-term care facilities, community-based social workers, health care agencies and other programs serving older adults. If you are interested in learning more about our screen, please call (718) 581-1472.

Community Partnerships

The Weinberg Center coordinates Westchester County's Multidisciplinary Team on Elder Abuse, a group of professionals who meet monthly to, develop action plans and coordinate services around complex cases of elder abuse. Since its inception in 2012, the team has addressed over a hundred complex cases of elder abuse. For more information, or to make a professional referral to the team, contact the team coordinator at Malya.Levin@theweinbergcenter.org.

MENTAL HEALTH SERVICES FOR OLDER ADULTS

As we age, we face transitions and challenges. Most of the time, we weather what comes our way without any difficulty. Sometimes, we can benefit from support and counseling. At these times, we are often unsure where to go. We hope this section will provide you, or those you care about, with information and guidance.

Individuals may face losses and experience stress about daily events and changes they face. They may become anxious or sad. When older adults face difficulties that interfere with day to day activities, it is best to reach out for help. If you are an older adult, or a person that is caring for an older adult, you should be aware that changes in your physical and/or emotional health could trigger symptoms related to anxiety, depression, or other mental disorders.

What types of difficulties do we face?

Although depression is not a part of normal aging, in older adults it causes distress, suffering and leads to impairments in physical, mental, and social functioning. Depression is one of the most common mental illnesses that affects older adults. Depression affects approximately 15 out of every 100 adults over age 65 in the United States. Depression is characterized by persistent feelings of sadness, hopelessness, worthlessness, and loss of interest in activities lasting two weeks or longer. A change in mood can be accompanied by changes in sleep, appetite, energy, memory problems, confusion, withdrawal from social situations, and irritability. Depression often interferes with the person's ability to complete everyday tasks over a prolonged period of time.

The recognition of depression in the elderly can be challenging because many older adults have physical illnesses that trigger or co-exist with depression. Life events, such as the loss of a loved one, retirement, and/or a lack of a supportive social network can trigger depression. Often individuals miss the opportunity to seek help because they assume the symptoms are "expected". However, in reality these symptoms should not be expected and compromise your quality of life. Untreated depression does not go away and leads to increased doctor visits, hospitalizations, isolation, and mortality.

What are some signs that I may be depressed?

If you are experiencing feelings of exhaustion, helplessness, hopelessness, and changes in mood or interest in things you usually enjoy, you may be depressed. It is important for you to seek guidance from someone who can help decide what you need. It is difficult to take any action to help yourself when depressed. Negative thinking and low mood are part of the depression and can keep individuals from seeking help. As you begin treatment, these feelings will go away.

What if I am uncomfortable talking to my doctor?

If you are uncomfortable talking with your doctor, there are other health care professionals to talk with. Time pressures resulting from insurance guidelines make it difficult for your doctor to adequately assess and diagnose your emotional and mental health needs. Other health professionals such as a social worker/case manager, counselor, psychologist, advanced practice nurse, geriatric psychiatrist, or a mental health counselor who specializes in this area are available to help you identify the appropriate care.

Is there any treatment for depression or other mental health disorders?

There are several options available to help individuals reduce their pain and suffering caused by the symptoms of depression and other mental health disorders. These treatments include medications and psychotherapy (talk therapy). Your doctor may start your treatment with medication to address the depression on a biological level. It may take some trial and error to find the right dosage that works for you. Do not be discouraged during this period. In addition to medication, your doctor or mental health provider may recommend that you participate in psychotherapy. In a safe environment, psychotherapy will often help you to cope with your feelings and help change some of the patterns in your life that may contribute to the illness.

What are some of the barriers to seeking treatment?

People who are experiencing symptoms of depression or anxiety worry about how they will be perceived if other family members or friends find out they have this diagnosis. Feelings of shame and self-doubt can result in the person isolating themselves from others. Often the fear of being treated differently causes individuals to delay seeking treatment, or even talking to others. Another common misconception is that insurance will not cover the cost of treatment. In fact, most insurance companies will adequately cover the cost of both medication and a variety of treatment modalities. In addition, lack of accessibility to the mental health treatment facility is another barrier to treatment.

If you are experiencing symptoms of depression or anxiety, remember to contact your doctor or a mental health professional. Options for help from professionals who specialize in working with older adults are listed below.

Weill Cornell Institute of Geriatric Psychiatry/New York Presbyterian Hospital
(across from The Westchester Mall in White Plains and in NYC on 61st and York)

Since 1994 the Weill Cornell Institute of Geriatric Psychiatry in White Plains has been the center for state of the art care for older adults with depression. We provide psychotherapy and medication services through participation in research programs. All of our studies seek to produce and share knowledge and programs that reduce the burden of depression and disability in older adults, many of whom have limited access to good care. Eligible individuals who participate in our studies receive free transportation and free treatment with talk therapy or FDA-approved medication. All studies provide treatment and we seek to promote excellence in care for older adults with depression.

In addition, we can provide psychotherapy services to older adults.

For a free screening for depression or more information, please contact the Weill Cornell Institute of Geriatric Psychiatry at (914) 997-4331.

http://psychiatry.weill.cornell.edu/weill-cornell-institute-geriatric-psychiatry

Family Services of Westchester, Inc. (FSW)

FSW is a private, non-profit, mental health and social service organization serving Westchester County since 1954. FSW has more than 55 years' experience providing licensed mental health services to older adults. In addition to geriatric mental health services, FSW offers a comprehensive range of both community-based and residential Elder Services to help Westchester's older residents maintain their highest possible level of independence in the community. A broad variety of services are provided to meet the needs of older adults and enhance their quality of life at whatever level they are functioning.

To schedule an appointment or consultation, please call the main number at (914) 937-2320.

For information regarding Geriatric Mental Health Services:
http://www.fsw.org/our-programs/older-adults/gatekeeper-and-pioap

Westchester Jewish Community Services (WJCS)

The Geriatric Mental Health Service at WJCS provides specialized counseling services to older adults, fifty five and over, and their families utilizing a variety of modalities, including individual, family and group treatments, psychiatric assessment and medication monitoring. Evidenced based practices, including cognitive behavioral therapy and problem solving treatment, address issues of aging, loss, disability, and changes in the family that can trigger anxiety and depression. Older adults recovering after discharge from psychiatric hospitalization also receive continuing treatment in an outpatient setting through our Service.

For more information or to apply for our services, contact Ellie Einzig, LCSWR, Coordinator, (914) 949-7699, ext. 429.

Phelps Memorial Hospital Center

Phelps Memorial Hospital Center has 238-beds and is a not-for-profit, acute care community hospital in Westchester County. Through their Senior Health and Internal Medicine Practice, The Phelps Memorial Hospital Center offers adult and geriatric primary care, including memory loss and depression screenings. The hospital also has an outpatient service called the Phelps Counseling Service that provides assessments, treatment, and support groups run by board certified psychiatrists, nurse practitioners and Licensed Clinical Social Workers.

To schedule an evaluation, please call (914) 366-3677.

https://phelpshospital.org/clinical-services/senior-health-internal-medicine/

St. Vincent's Hospital Westchester

St. Vincent's Hospital in Westchester is one of the largest providers of mental health counseling in the Westchester area. The Geriatric Inpatient Program at St. Vincent's Hospital offers a therapeutic environment for older adults aimed at promoting safety, mental health and physical well-being for adults suffering from psychiatric disorders.

To schedule an evaluation or refer a client, please call the Evaluation and Referral Service at (914) 925-5320.
http://www.stvincentswestchester.org/outpatient-programs/geriatric-services

The Mental Health Association of Westchester County, Inc. (MHA)

The Mental Health Association of Westchester County, Inc. offers clinic services to individuals of all ages, including older adults. Clinics are located in multiple locations throughout Westchester County as well as in Rockland.

MHA's web site, **www.mhawestchester.org** offers a full description of services and locations.

Individuals wishing to schedule an appointment at a convenient location can contact our Central Scheduler at (914) 345-0700, ext. 7350.

The Westchester Public/Private Partnership for Aging Services (the "Partnership") is a not for profit organization founded in 1991 and, as its name implies, is a joint venture between Westchester County, the public partner, and the Westchester business community, voluntary service agencies and consumers, the private partners. The private partners work with the Westchester Department of Senior Programs and Services to develop resources and provide substantial services to advance and protect the rights of seniors. The Partnership's mission is to help seniors age with independence and dignity in their home communities.

The Partnership recruits corporations to contribute unrestricted funds, underwrite specific programs or donate in-kind services that expand needed services to the elderly. To this end, the Partnership has raised more than 3 million dollars to date to enrich the quality of life for older adults and their families.

Throughout the years, the Partnership has committed its resources to supporting many issues, including improving community-based long term care options; preventing elder abuse, and intervening when it is found; and offering caregivers information and respite. As part of its mandate for educating the public on legal issues affecting the elderly, the Partnership was and continues to be one of the organizations that has underwritten the cost for the publication and printing of this Q & A

Some of the other recent accomplishments of the Partnership include:

1. Sponsoring Senior Law Day programs throughout Westchester County, run by attorneys, accountants, financial planners and geriatric social workers to educate seniors and caregivers about legal, financial and healthcare issues affecting the elderly and their families. Please visit http://www.seniorlawday.info/calendar-of-events/ for event listings. During the COVID-19 pandemic, the Senior Law Day Collaborative moved its program virtual and has developed a complete library of video presentations here. https://www.seniorlawday.info/2020-webinars/

   Topics include:

   - Medicaid and Medicaid Home Services
   - Elder Law 101

- How Robust is Your Financial Plan?
- Staying Safe while Navigating the Internet
- Online scams
- Essential online health information

2. Establishing the Telehealth Intervention Program for Seniors ("TIPS") which delivers remote patient monitoring targeting low income older adults with high health risks.

3. Advancing the Livable Communities initiative by funding comprehensive analysis of the institutions, public facilities, land use, transportation options and environmental factors in all 43 municipalities in Westchester County to enable seniors to grow old in their homes and remain vital members of their neighborhood.

4. Developing an Ambassadors For Successful Aging Navigation Program to connect Seniors to services to enhance their independence in the community.

5. Promoting the Westchester Alliance which is a coalition which works with local colleges and universities to educate college aged residents about the issues affecting the elderly and to find ways to incorporate this information into academic course offerings.

6. Educating Retirees and all Seniors by supporting SENIORU, a fully accredited college degree program at Concordia College.

7. Creating the Caregiver Coaching Program, having garnered special recognition from the AARP, trains volunteers to provide one-on-one support to assist caregivers in making more informed decisions.

8. Initiating the SMART program which is a model intergenerational literacy program that recruits and trains older adult volunteers from the community to read with and mentor children in public schools throughout Westchester County.

9. Developing MAP: My Aging Plan which is a step-by-step guide on how to age successfully starting in your 20's and following through to your 80's and beyond.

10. Continuing the New York Southern Area Aging Network or "NY-SANN" initiative, which is a consortium of government and senior service providers representing 2.2 million older adults residing in southern New York State comprising New York City, Long Island and the Hudson Valley. These geographic areas represent 69% of the State's older adult population. The NY-SANN Consortium will examine strategies to alleviate the serious workforce shortage for senior services in this region.

11. Providing funding for safe centers for "at-risk" seniors who have been neglected, threatened or physically or sexually abused. These safe centers have provided assistance and information to thousands of seniors and caregivers.

12. Initiating the long term care insurance education and outreach program dedicated to informing and educating the general public about long term care insurance. This program has furnished information to 4,200 businesses as well as sponsored presentations which have reached over 3,000 individual seniors.

13. Supporting programs for Health and Wellness, educating grandparents raising grandchildren, funding transportation of seniors to volunteer assignments, and promoting intergenerational literacy programs.

Notwithstanding the impressive private membership of its Board – currently chaired by Judy S. Fink, Director of Geriatric Services at Westchester Jewish Community Services – the Partnership could never have completed its many accomplishments without the support of its public partner, the Westchester County Department of Senior Programs and Services. This agency is led by its extraordinary Commissioner, Mae Carpenter, the founder of the Partnership in 1990. Commissioner Carpenter has taken a leadership position, on a national scale, to develop an agenda to address issues affecting the senior community in Westchester County and across the Country.

What Other Programs Are Available to Westchester Residents?

Westchester Library System (WLS) includes 38 member libraries throughout Westchester County. One of many services that WLS offers is the **Senior Benefits Individual Counseling Services (SBICS)** program. Fueled by more than 75 rigorously trained volunteers, SBICS provide free, personalized assistance in reviewing and updating Medicare and related senior-directed benefits. Available

throughout the year, counselors can be reached on the SBICS helpline via email (sbic@wlsmail.org) and telephone (914-231-3260). For more information, see the SBICS website: (www.westchesterlibraries.org/sbics). (Note: We are hopeful that the SBICS will return to in-person library-based services in 2021.)

TWO ADDITIONAL PROGRAMS OF NOTE:

Music and Memory at the Library – Discover a valuable support for those caring for an adult at home experiencing dementia. Receive help in building a personalized music playlist, using library resources, to provide a point of connection and familiarity for the one in your care. Appropriate personal music devices available for extended loan.
For more information, visit (https://www.westchesterlibraries.org/services-programs/music-and-memory/) or email (MusicAndMemory@wlsmail.org).

VisionLabs: Reading for a Lifetime – Our staff work to connect you to resources and services that support those with low vision and/or motor-challenges that inhibit reading. To find out more, visit the VisionLabs website: (https://wikis.westchesterlibraries.org/sbic/visionlabs/) or email (outreach@wlsmail.org).

And, of course, your local library! - Local libraries offer rich, varied, personalized services to Westchester County seniors. These services – designed to inform, enrich, and engage – take place in many forms. For example:

- home delivery of books for those who can't get to the library,
- one-to-one instruction on the use of computers, mobile devices, and software,
- a calendar full of book discussions, concerts and classes – online and in person
- quiet spaces for reading and group discussions.

Most importantly, in every public library are staff who are prepared to answer questions about essential resources and services. With a view toward what is local and accessible, as well as knowledge of what is available across our county and beyond, librarians and libraries can connect community members to the information they need.

A full list of Westchester's public libraries is available at www.westchesterlibraries.org/

Appendix A

Health Care Proxy

Health Care Proxy

Appointing Your Health Care Agent in New York State

The New York Health Care Proxy Law allows you to appoint someone you trust — for example, a family member or close friend – to make health care decisions for you if you lose the ability to make decisions yourself. By appointing a health care agent, you can make sure that health care providers follow your wishes. Your agent can also decide how your wishes apply as your medical condition changes. Hospitals, doctors and other health care providers must follow your agent's decisions as if they were your own. You may give the person you select as your health care agent as little or as much authority as you want. You may allow your agent to make all health care decisions or only certain ones. You may also give your agent instructions that he or she has to follow. This form can also be used to document your wishes or instructions with regard to organ and/or tissue donation.

About the Health Care Proxy Form

This is an important legal document. Before signing, you should understand the following facts:

1. This form gives the person you choose as your agent the authority to make all health care decisions for you, including the decision to remove or provide life-sustaining treatment, unless you say otherwise in this form. "Health care" means any treatment, service or procedure to diagnose or treat your physical or mental condition.
2. Unless your agent reasonably knows your wishes about artificial nutrition and hydration (nourishment and water provided by a feeding tube or intravenous line), he or she will not be allowed to refuse or consent to those measures for you.
3. Your agent will start making decisions for you when your doctor determines that you are not able to make health care decisions for yourself.
4. You may write on this form examples of the types of treatments that you would not desire and/or those treatments that you want to make sure you receive. The instructions may be used to limit the decision-making power of the agent. Your agent must follow your instructions when making decisions for you.
5. You do not need a lawyer to fill out this form.
6. You may choose any adult (18 years of age or older), including a family member or close friend, to be your agent. If you select a doctor as your agent, he or she will have to choose between acting as your agent or as your attending doctor because a doctor cannot do both at the same time. Also, if you are a patient or resident of a hospital, nursing home or mental hygiene facility, there are special restrictions about naming someone who works for that facility as your agent. Ask staff at the facility to explain those restrictions.
7. Before appointing someone as your health care agent, discuss it with him or her to make sure that he or she is willing to act as your agent. Tell the person you choose that he or she will be your health care agent. Discuss your health care wishes and this form with your agent. Be sure to give him or her a signed copy. Your agent cannot be sued for health care decisions made in good faith.
8. If you have named your spouse as your health care agent and you later become divorced or legally separated, your former spouse can no longer be your agent by law, unless you state otherwise. If you would like your former spouse to remain your agent, you may note this on your current form and date it or complete a new form naming your former spouse.
9. Even though you have signed this form, you have the right to make health care decisions for yourself as long as you are able to do so, and treatment cannot be given to you or stopped if you object, nor will your agent have any power to object.
10. You may cancel the authority given to your agent by telling him or her or your health care provider orally or in writing.
11. Appointing a health care agent is voluntary. No one can require you to appoint one.
12. You may express your wishes or instructions regarding organ and/or tissue donation on this form.

Frequently Asked Questions

Why should I choose a health care agent?

If you become unable, even temporarily, to make health care decisions, someone else must decide for you. Health care providers often look to family members for guidance. Family members may express what they think your wishes are related to a particular treatment. However, in New York State, only a health care agent you appoint has the legal authority to make treatment decisions if you are unable to decide for yourself. Appointing an agent lets you control your medical treatment by:

- Allowing decisions on your behalf as you would want them decided;
- choosing one person to make health care decisions because you think that person would make the best decisions;
- choosing one person to avoid conflict or confusion among family members and/or significant others.

You may also appoint an alternate agent to take over if your first choice cannot make decisions for you.

Who can be a health care agent?

Anyone 18 years of age or older can be a health care agent. The person you are appointing as your agent or your alternate agent cannot sign as a witness on your Health Care Proxy form.

How do I appoint a health care agent?

All competent adults, 18 years of age or older, can appoint a health care agent by signing a form called a Health Care Proxy. You don't need a lawyer or a notary, just two adult witnesses. Your agent cannot sign as a witness. You can use the form printed here, but you don't have to use this form.

When would my health care agent begin to make health care decisions for me?

Your health care agent would begin to make health care decisions after your doctor decides that you are not able to make your own health care decisions. As long as you are able to make health care decisions for yourself, you will have the right to do so.

What decisions can my health care agent make?

Unless you limit your health care agent's authority, your agent will be able to make any health care decision that you could have made if you were able to decide for yourself. Your agent can agree that you should receive treatment, choose among different treatments and decide that treatments should not be provided, in accordance with your wishes and interests. However, your agent can only make decisions about artificial nutrition and hydration (nourishment and water provided by feeding tube or intravenous line) if he or she knows your wishes from what you have said or what you have written. The Health Care Proxy form does not give your agent the power to make non-health care decisions for you, such as financial decisions.

Why do I need to appoint a health care agent if I'm young and healthy?

Appointing a health care agent is a good idea even though you are not elderly or terminally ill. A health care agent can act on your behalf if you become even temporarily unable to make your own health care decisions (such as might occur if you are under general anesthesia or have become comatose because of an accident). When you again become able to make your own health care decisions, your health care agent will no longer be authorized to act.

How will my health care agent make decisions?

Your agent must follow your wishes, as well as your moral and religious beliefs. You may write instructions on your Health Care Proxy form or simply discuss them with your agent.

How will my health care agent know my wishes?

Having an open and frank discussion about your wishes with your health care agent will put him or her in a better position to serve your interests. If your agent does not know your wishes or beliefs, your agent is legally required to act in your best interest. Because this is a major responsibility for the person you appoint as your health care agent, you should have a discussion with the person about what types of treatments you would or would not want under different types of circumstances, such as:

- whether you would want life support initiated/continued/removed if you are in a permanent coma;
- whether you would want treatment initiated/continued/removed if you have a terminal illness;
- whether you would want artificial nutrition and hydration initiated/withheld or continued or withdrawn and under what types of circumstances.

Can my health care agent overrule my wishes or prior treatment instructions?

No. Your agent is obligated to make decisions based on your wishes. If you clearly expressed particular wishes, or gave particular treatment instructions, your agent has a duty to follow those wishes or instructions unless he or she has a good faith basis for believing that your wishes changed or do not apply to the circumstances.

Who will pay attention to my agent?

All hospitals, nursing homes, doctors and other health care providers are legally required to provide your health care agent with the same information that would be provided to you and to honor the decisions by your agent as if they were made by you. If a hospital or nursing home objects to some treatment options (such as removing certain treatment) they must tell you or your agent BEFORE or upon admission, if reasonably possible.

What if my health care agent is not available when decisions must be made?

You may appoint an alternate agent to decide for you if your health care agent is unavailable, unable or unwilling to act when decisions must be made. Otherwise, health care providers will make health care decisions for you that follow instructions you gave while you were still able to do so. Any instructions that you write on your Health Care Proxy form will guide health care providers under these circumstances.

What if I change my mind?

It is easy to cancel your Health Care Proxy, to change the person you have chosen as your health care agent or to change any instructions or limitations you have included on the form. Simply fill out a new form. In addition, you may indicate that your Health Care Proxy expires on a specified date or if certain events occur. Otherwise, the Health Care Proxy will be valid indefinitely. If you choose your spouse as your health care agent or as your alternate, and you get divorced or legally separated, the

appointment is automatically canceled. However, if you would like your former spouse to remain your agent, you may note this on your current form and date it or complete a new form naming your former spouse.

Can my health care agent be legally liable for decisions made on my behalf?

No. Your health care agent will not be liable for health care decisions made in good faith on your behalf. Also, he or she cannot be held liable for costs of your care, just because he or she is your agent.

Is a Health Care Proxy the same as a living will?

No. A living will is a document that provides specific instructions about health care decisions. You may put such instructions on your Health Care Proxy form. The Health Care Proxy allows you to choose someone you trust to make health care decisions on your behalf. Unlike a living will, a Health Care Proxy does not require that you know in advance all the decisions that may arise. Instead, your health care agent can interpret your wishes as medical circumstances change and can make decisions you could not have known would have to be made.

Where should I keep my Health Care Proxy form after it is signed?

Give a copy to your agent, your doctor, your attorney and any other family members or close friends you want. Keep a copy in your wallet or purse or with other important papers, but not in a location where no one can access it, like a safety deposit box. Bring a copy if you are admitted to the hospital, even for minor surgery, or if you undergo outpatient surgery.

May I use the Health Care Proxy form to express my wishes about organ and/or tissue donation?

Yes. Use the optional organ and tissue donation section on the Health Care Proxy form and be sure to have the section witnessed by two people. You may specify that your organs and/or tissues be used for transplantation, research or educational purposes. Any limitation(s) associated with your wishes should be noted in this section of the proxy. Failure to include your wishes and instructions on your Health Care Proxy form will not be taken to mean that you do not want to be an organ and/ or tissue donor.

Can my health care agent make decisions for me about organ and/or tissue donation?

Yes. As of August 26, 2009, your health care agent is authorized to make decisions after your death, but only those regarding organ and/or tissue donation. Your health care agent must make such decisions as noted on your Health Care Proxy form.

Who can consent to a donation if I choose not to state my wishes at this time?

It is important to note your wishes about organ and/or tissue donation to your health care agent, the person designated as your decedent's agent, if one has been appointed, and your family members. New York Law provides a list of individuals who are authorized to consent to organ and/or tissue donation on your behalf. They are listed in order of priority: your health care agent; your decedent's agent; your spouse, if you are not legally separated, or your domestic partner; a son or daughter 18 years of age or older; either of your parents; a brother or sister 18 years of age or older; or a guardian appointed by a court prior to the donor's death.

Health Care Proxy Form Instructions

Item (1)
Write the name, home address and telephone number of the person you are selecting as your agent.

Item (2)
If you want to appoint an alternate agent, write the name, home address and telephone number of the person you are selecting as your alternate agent.

Item (3)
Your Health Care Proxy will remain valid indefinitely unless you set an expiration date or condition for its expiration. This section is optional and should be filled in only if you want your Health Care Proxy to expire.

Item (4)
If you have special instructions for your agent, write them here. Also, if you wish to limit your agent's authority in any way, you may say so here or discuss them with your health care agent. If you do not state any limitations, your agent will be allowed to make all health care decisions that you could have made, including the decision to consent to or refuse life-sustaining treatment.

If you want to give your agent broad authority, you may do so right on the form. Simply write: *I have discussed my wishes with my health care agent and alternate and they know my wishes including those about artificial nutrition and hydration.*

If you wish to make more specific instructions, you could say:

If I become terminally ill, I do/don't want to receive the following types of treatments....

If I am in a coma or have little conscious understanding, with no hope of recovery, then I do/ don't want the following types of treatments:....

If I have brain damage or a brain disease that makes me unable to recognize people or speak and there is no hope that my condition will improve, I do/don't want the following types of treatments:....

I have discussed with my agent my wishes about_____ and I want my agent to make all decisions about these measures

Examples of medical treatments about which you may wish to give your agent special instructions are listed below. This is not a complete list:

- artificial respiration
- artificial nutrition and hydration (nourishment and water provided by feeding tube)
- cardiopulmonary resuscitation (CPR)
- antipsychotic medication
- electric shock therapy
- antibiotics
- surgical procedures
- dialysis
- transplantation
- blood transfusions
- abortion
- sterilization

Item (5)
You must date and sign this Health Care Proxy form. If you are unable to sign yourself, you may direct someone else to sign in your presence. Be sure to include your address.

Item (6)
You may state wishes or instructions about organ and /or tissue donation on this form. New York law does provide for certain individuals in order of priority to consent to an organ and/ or tissue donation on your behalf: your health care agent, your decedent's agent, your spouse, if you are not legally separated, or your domestic partner, a son or daughter 18 years of age or older, either of your parents, a brother or sister 18 years of age or older, a guardian appointed by a court prior to the donor's death.

Item (7)
Two witnesses 18 years of age or older must sign this Health Care Proxy form. The person who is appointed your agent or alternate agent cannot sign as a witness.

Health Care Proxy

(1) I, _____

hereby appoint _____
(name, home address and telephone number)

_____

_____

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This proxy shall take effect only when and if I become unable to make my own health care decisions.

(2) Optional: Alternate Agent

If the person I appoint is unable, unwilling or unavailable to act as my health care agent, I hereby appoint _____
(name, home address and telephone number)

_____

_____

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise.

(3) Unless I revoke it or state an expiration date or circumstances under which it will expire, this proxy shall remain in effect indefinitely. (*Optional: If you want this proxy to expire, state the date or conditions here.)* This proxy shall expire *(specify date or conditions):*

_____

_____

(4) Optional: I direct my health care agent to make health care decisions according to my wishes and limitations, as he or she knows or as stated below. *(If you want to limit your agent's authority to make health care decisions for you or to give specific instructions, you may state your wishes or limitations here.)* I direct my health care agent to make health care decisions in accordance with the following limitations and/or instructions *(attach additional pages as necessary):*

_____

_____

In order for your agent to make health care decisions for you about artificial nutrition and hydration *(nourishment and water provided by feeding tube and intravenous line),* your agent must reasonably know your wishes. You can either tell your agent what your wishes are or include them in this section. See instructions for sample language that you could use if you choose to include your wishes on this form, including your wishes about artificial nutrition and hydration.

SAMPLE

(5) Your Identification *(please print)*

Your Name _____

Your Signature _____ Date _____

Your Address _____

(6) Optional: Organ and/or Tissue Donation

I hereby make an anatomical gift, to be effective upon my death, of:
(check any that apply)

☐ Any needed organs and/or tissues

☐ The following organs and/or tissues _____

_____

☐ Limitations _____

If you do not state your wishes or instructions about organ and/or tissue donation on this form, it will not be taken to mean that you do not wish to make a donation or prevent a person, who is otherwise authorized by law, to consent to a donation on your behalf.

Your Signature _____ Date _____

(7) Statement by Witnesses *(Witnesses must be 18 years of age or older and cannot be the health care agent or alternate.)*

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Witness 1

Date _____

Name *(print)* _____

Signature _____

Address _____

_____

Witness 2

Date _____

Name *(print)* _____

Signature _____

Address _____

_____

SAMPLE

NOTES:

If you wish to print out a copy of the Health Care Proxy to fill out, please visit:

https://www.health.ny.gov/publications/1430.pdf

We often recommend that a Health Care Proxy be accompanied by a HIPPA form, which you can find here:

https://www.nycourts.gov/forms/Hipaa_fillable.pdf

OR

https://health.westchestergov.com/images/stories/pdfs/HIPPA-Spanish.pdf

Appendix B

New York Living Will

APPENDIX B

NEW YORK LIVING WILL

I, _____, being of sound mind, make this statement as a directive to be followed if I become permanently unable to participate in decisions regarding my medical care. These instructions reflect my firm and settled commitment to decline medical treatment under the circumstances indicated below.

I direct my attending physician and other medical personnel to withhold or withdraw treatment that serves only to prolong the process of dying if I should be in an incurable or irreversible mental or physical condition with no reasonable expectation of recovery.

These instructions apply if I am: a) in a terminal condition; b) permanently unconscious; or c) if I am conscious but have irreversible brain damage and will never regain the ability to make decisions and express my wishes.

I direct that treatment be limited to measures to keep me comfortable and to relieve pain, including any pain that might occur by withholding or withdrawing treatment. While I understand that I am not legally required to be specific about future treatments; if I am in the condition(s) described above, I feel especially strong about the following forms of treatment.

- I do not want cardiac resuscitation.
- I do not want mechanical respiration.
- I do not want tube feeding.
- I do not want antibiotics.
- I do want maximum pain relief.

Other instructions (insert personal instructions):

These directions express my legal right to refuse treatment under the laws of the State of New York. Unless I have revoked this instrument or otherwise clearly and explicitly indicated that I have changed my mind, it is my unequivocal intent that my instructions as set forth in this document be faithfully carried out.

Signature: _____

Address: _____

Date: _____

SAMPLE

Statement By Witnesses (Must be 18 or Older)

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Witness: _____

Address: _____

Witness: _____

Address: _____

KEEP SIGNED ORIGINAL WITH YOUR PERSONAL PAPERS AT HOME. GIVE COPIES OF THE SIGNED ORIGINAL TO YOUR DOCTOR, FAMILY, LAWYER AND OTHERS WHO MIGHT BE INVOLVED IN YOUR CARE.

SAMPLE

Appendix C

MOLST

Medical Orders for Life-Sustaining Treatment

NEW YORK STATE DEPARTMENT OF HEALTH

Medical Orders for Life-Sustaining Treatment (MOLST)

THE PATIENT KEEPS THE ORIGINAL MOLST FORM DURING TRAVEL TO DIFFERENT CARE SETTINGS. THE PHYSICIAN OR NURSE PRACTITIONER KEEPS A COPY.

LAST NAME/FIRST NAME/MIDDLE INITIAL OF PATIENT

ADDRESS

CITY/STATE/ZIP

DATE OF BIRTH (MM/DD/YYYY) ☐ Male ☐ Female eMOLST NUMBER (THIS IS NOT AN eMOLST FORM)

Do-Not-Resuscitate (DNR) and Other Life-Sustaining Treatment (LST)

This is a medical order form that tells others the patient's wishes for life-sustaining treatment. A health care professional must complete or change the MOLST form based on the patient's current medical condition, values, wishes, and MOLST Instructions. If the patient is unable to make medical decisions, the orders should reflect patient wishes, as best understood by the health care agent or surrogate. A physician or nurse practitioner must sign the MOLST form. All health care professionals must follow these medical orders as the patient moves from one location to another, unless a physician or nurse practitioner examines the patient, reviews the orders, and changes them.

MOLST is generally for patients with serious health conditions. The patient or other decision-maker should work with the physician or nurse practitioner and consider asking the physician or nurse practitioner to fill out a MOLST form if the patient:

- Wants to avoid or receive any or all life-sustaining treatment.
- Resides in a long-term care facility or requires long-term care services.
- Might die within the next year.

If the patient has an intellectual or developmental disability (I/DD) and lacks the capacity to decide, the doctor (not a nurse practitioner) must follow special procedures and attach the completed Office for People with Developmental Disabilities (OPWDD) legal requirements checklist before signing the MOLST. See page 4.

SECTION A Resuscitation Instructions When the Patient Has No Pulse and/or Is Not Breathing

Check **one**:

☐ **CPR Order: Attempt Cardio-Pulmonary Resuscitation**
CPR involves artificial breathing and forceful pressure on the chest to try to restart the heart. It usually involves electric shock (defibrillation) and a plastic tube down the throat into the windpipe to assist breathing (intubation). It means that all medical treatments will be done to prolong life when the heart stops or breathing stops, including being placed on a breathing machine and being transferred to the hospital.

☐ **DNR Order: Do Not Attempt Resuscitation (Allow Natural Death)**
This means do not begin CPR, as defined above, to make the heart or breathing start again if either stops.

SECTION B Consent for Resuscitation Instructions (Section A)

The patient can make a decision about resuscitation if he or she has the ability to decide about resuscitation. If the patient does NOT have the ability to decide about resuscitation and has a health care proxy, the health care agent makes this decision. If there is no health care proxy, another person will decide, chosen from a list based on NYS law. Individuals with I/DD who do not have capacity and do not have a health care proxy must follow SCPA 1750-b.

SIGNATURE ☐ Check if verbal consent (Leave signature line blank) DATE/TIME

PRINT NAME OF DECISION-MAKER

PRINT FIRST WITNESS NAME PRINT SECOND WITNESS NAME

Who made the decisions? ☐ Patient ☐ Health Care Agent ☐ Public Health Law Surrogate ☐ Minor's Parent/Guardian ☐ §1750-b Surrogate*

SECTION C Physician or Nurse Practitioner Signature for Sections A and B

PHYSICIAN OR NURSE PRACTITIONER SIGNATURE* PRINT PHYSICIAN OR NURSE PRACTITIONER NAME DATE/TIME

PHYSICIAN OR NURSE PRACTITIONER LICENSE NUMBER PHYSICIAN OR NURSE PRACTITIONER PHONE/PAGER NUMBER

SECTION D Advance Directives

Check all advance directives known to have been completed:

☐ Health Care Proxy ☐ Living Will ☐ Organ Donation ☐ Documentation of Oral Advance Directive

***If this decision is being made by a 1750-b surrogate, a physician must sign the MOLST.**

DOH-5003 (12/18) p 1 of 4

THE PATIENT KEEPS THE ORIGINAL MOLST FORM DURING TRAVEL TO DIFFERENT CARE SETTINGS. THE PHYSICIAN OR NURSE PRACTITIONER KEEPS A COPY.

LAST NAME/FIRST NAME/MIDDLE INITIAL OF PATIENT DATE OF BIRTH (MM/DD/YYYY)

SECTION E Orders For Other Life-Sustaining Treatment and Future Hospitalization When the Patient has a Pulse and the Patient is Breathing

Life-sustaining treatment may be ordered for a trial period to determine if there is benefit to the patient. **If a life-sustaining treatment is started, but turns out not to be helpful, the treatment can be stopped. Before stopping treatment, additional procedures may be needed as indicated on page 4.**

Treatment Guidelines No matter what else is chosen, the patient will be treated with dignity and respect, and health care providers will offer comfort measures. *Check one:*

☐ **Comfort measures only** Comfort measures are medical care and treatment provided with the primary goal of relieving pain and other symptoms and reducing suffering. Reasonable measures will be made to offer food and fluids by mouth. Medication, turning in bed, wound care and other measures will be used to relieve pain and suffering. Oxygen, suctioning and manual treatment of airway obstruction will be used as needed for comfort.

☐ **Limited medical interventions** The patient will receive medication by mouth or through a vein, heart monitoring and all other necessary treatment, based on MOLST orders.

☐ **No limitations on medical interventions** The patient will receive all needed treatments.

Instructions for Intubation and Mechanical Ventilation *Check one:*

☐ **Do not intubate (DNI)** Do not place a tube down the patient's throat or connect to a breathing machine that pumps air into and out of lungs. Treatments are available for symptoms of shortness of breath, such as oxygen and morphine. (This box should not be checked if full CPR is checked in Section A.)

☐ **A trial period** *Check one or both:*

- ☐ **Intubation and mechanical ventilation**
- ☐ **Noninvasive ventilation (e.g. BIPAP), if the health care professional agrees that it is appropriate**

☐ **Intubation and long-term mechanical ventilation, if needed** Place a tube down the patient's throat and connect to a breathing machine as long as it is medically needed.

Future Hospitalization/Transfer *Check one:*

☐ **Do not send to the hospital unless pain or severe symptoms cannot be otherwise controlled.**

☐ **Send to the hospital, if necessary, based on MOLST orders.**

Artificially Administered Fluids and Nutrition When a patient can no longer eat or drink, liquid food or fluids can be given by a tube inserted in the stomach or fluids can be given by a small plastic tube (catheter) inserted directly into the vein. If a patient chooses not to have either a feeding tube or IV fluids, food and fluids are offered as tolerated using careful hand feeding. **Additional procedures may be needed as indicated on page 4.**
Check one each for feeding tube and IV fluids:

☐ **No feeding tube** ☐ **No IV fluids**

☐ **A trial period of feeding tube** ☐ **A trial period of IV fluids**

☐ **Long-term feeding tube, if needed**

Antibiotics *Check one:*

☐ **Do not use antibiotics.** Use other comfort measures to relieve symptoms.

☐ **Determine use or limitation of antibiotics when infection occurs.**

☐ **Use antibiotics** to treat infections, if medically indicated.

Other Instructions about starting or stopping treatments discussed with the doctor or nurse practitioner or about other treatments not listed above (dialysis, transfusions, etc.).

Consent for Life-Sustaining Treatment Orders (Section E) (Same as Section B, which is the consent for Section A)

SIGNATURE ☐ Check if verbal consent (Leave signature line blank) DATE/TIME

PRINT NAME OF DECISION-MAKER

PRINT FIRST WITNESS NAME PRINT SECOND WITNESS NAME

Who made the decisions? ☐ Patient ☐ Health Care Agent ☐ Based on clear and convincing evidence of patient's wishes ☐ Public Health Law Surrogate ☐ Minor's Parent/Guardian ☐ §1750-b Surrogate*

Physician or Nurse Practitioner Signature for Section E

PHYSICIAN OR NURSE PRACTITIONER SIGNATURE* PRINT PHYSICIAN OR NURSE PRACTITIONER NAME DATE/TIME

***If this decision is being made by a 1750-b surrogate, a physician must sign the MOLST.**

THE PATIENT KEEPS THE ORIGINAL MOLST FORM DURING TRAVEL TO DIFFERENT CARE SETTINGS. THE PHYSICIAN OR NURSE PRACTITIONER KEEPS A COPY.

LAST NAME/FIRST NAME/MIDDLE INITIAL OF PATIENT DATE OF BIRTH (MM/DD/YYYY)

SECTION F Review and Renewal of MOLST Orders on this MOLST Form

The physician or nurse practitioner must review the form from time to time as the law requires, and also:

- If the patient moves from one location to another to receive care; or
- If the patient has a major change in health status (for better or worse); or
- If the patient or other decision-maker changes his or her mind about treatment.

Date/Time	Reviewer's Name and Signature	Location of Review (e.g., Hospital, NH, Physician's or Nurse Practitioner's Office)	Outcome of Review
			☐ No change ☐ Form voided, new form completed ☐ Form voided, **no** new form
			☐ No change ☐ Form voided, new form completed ☐ Form voided, **no** new form
			☐ No change ☐ Form voided, new form completed ☐ Form voided, **no** new form
			☐ No change ☐ Form voided, new form completed ☐ Form voided, **no** new form
			☐ No change ☐ Form voided, new form completed ☐ Form voided, **no** new form
			☐ No change ☐ Form voided, new form completed ☐ Form voided, **no** new form
			☐ No change ☐ Form voided, new form completed ☐ Form voided, **no** new form
			☐ No change ☐ Form voided, new form completed ☐ Form voided, **no** new form
			☐ No change ☐ Form voided, new form completed ☐ Form voided, **no** new form
			☐ No change ☐ Form voided, new form completed ☐ Form voided, **no** new form
			☐ No change ☐ Form voided, new form completed ☐ Form voided, **no** new form

THE PATIENT KEEPS THE ORIGINAL MOLST FORM DURING TRAVEL TO DIFFERENT CARE SETTINGS. THE PHYSICIAN OR NURSE PRACTITIONER KEEPS A COPY.

LAST NAME/FIRST NAME/MIDDLE INITIAL OF PATIENT DATE OF BIRTH (MM/DD/YYYY)

Requirements for Completing the MOLST for Individuals with Intellectual or Developmental Disabilities

Completing the MOLST for individuals with I/DD who lack capacity to make their own health care decisions and do not have a health care proxy:

- The law governing the decision-making process differs for individuals with I/DD. Surrogate's Court Procedure Act (SCPA) Section 1750-b must be followed when making a decision for an individual with I/DD who lacks capacity and does not have a health care proxy.
- MOLST may only be signed by a **physician**, not a nurse practitioner.
- Completion of the **MOLST legal requirements checklist for individuals with I/DD**, including notification of certain parties and resolution of any objections, is **mandatory prior to completion of MOLST**. The checklist is available on the NYS OPWDD website.
- The checklist should be completed when an authorized surrogate makes a decision to **withhold or withdraw life sustaining treatment (LST)** from an individual with I/DD. There are specific medical criteria, included in Step 4 of the checklist. The individual's medical condition must meet the specified medical criteria **at the time the request to withhold or withdraw treatment is made**.
- **Trials** – whether or not a new checklist is required following an unsuccessful trial of LST depends on the parameters of the trial, as specified in Step 2 of the checklist. If Step 2 of the checklist has provided that a trial for LST is to end after a specific period of time or the occurrence of a specific event, it may not be necessary to complete a new checklist following the trial. However, if a trial period is open ended, and the authorized surrogate subsequently decides to request withdrawal of the LST, a new checklist would be required.
- The checklist and 1750-b process apply to individuals with I/DD, regardless of their age or residential setting.

MOLST | MEDICAL ORDERS FOR LIFE-SUSTAINING TREATMENT

General Instructions for the Legal Requirements Checklists for Adult Patients and Glossary

The MOLST form is a medical order form that tells others the patient's medical orders for life-sustaining treatment. All health care professionals must follow these medical orders as the patient moves from one location to another, unless a physician or nurse practitioner examines the patient, reviews the orders, and changes them.

MOLST is generally for patients with serious health conditions. Physicians or nurse practitioners should consider consulting with the patient about completing a MOLST form if the patient:

- Wants to avoid or receive life-sustaining treatment.
- Resides in a long-term care facility or requires long-term care services.
- Might die within the next year.

These instructions and checklists are intended to assist health care professionals in completing the MOLST form with adult patients and/or the patients' authorized health care decision-makers. They are NOT intended for use with minor patients, or patients with developmental disabilities who lack medical decision-making capacity, or patients with mental illness in a mental hygiene facility.

General Instructions

The MOLST form must be completed based on the patient's current medical condition, values, wishes, and these MOLST instructions. Completion of the MOLST begins with a conversation or a series of conversations between the patient, the health care agent or the surrogate, and a qualified, trained health care professional that defines the patient's goals for care, reviews possible treatment options on the entire MOLST form, and ensures shared, informed medical decision-making. The conversation should be documented in the medical record. The patient or other medical decision-maker must consent to the MOLST orders, with the exception of patients covered by Checklist #4 (for adult hospital, hospice or nursing home patients without medical decision-making capacity who do not have a health care proxy or a Public Health Law surrogate).

Although the conversation(s) about goals and treatment options may be initiated by any qualified and trained health care professional, a licensed physician or nurse practitioner must always, at a minimum: (i) confer with the patient and/or the patient's health care agent or surrogate about the patient's diagnosis, prognosis, goals for care, treatment preferences, and consent by the appropriate decision-maker, and (ii) sign the orders derived from that discussion. If the physician is licensed in a border state, the physician must insert the abbreviation for the state in which he/she is licensed, along with the license number.

Completion of both the first and second pages of the MOLST form is strongly encouraged. However, the patient or decision-maker (i.e., a health care agent or surrogate) may not be physically or emotionally prepared to reach a decision concerning every treatment option on the form in a single meeting. Completion of only page 1 of the MOLST form (concerning CPR/DNR) is permissible, and page 2 (Section E) may be completed at a later time. If a patient or decision-maker can reach a decision on one or more treatment options, but not others, on page 2, the physician or nurse practitioner may cross out the portion of the form with the treatment option(s) for which there is no decision and write "Decision Deferred" next to those treatment option(s). If the patient or decision-maker reaches a decision concerning that treatment option(s) at a later time, a new form must be completed and signed by a physician or nurse practitioner, indicating all of the patient's or decision-maker's decisions.

Verbal orders are acceptable with a follow-up signature by a NYS licensed physician or nurse practitioner or a border state physician in accordance with facility/community policy. Verbal orders must be authenticated under Medicare and Medicaid hospital conditions of participation.

Printing the form on bright "pulsar" pink, heavy stock paper is strongly encouraged. When EMS personnel respond to an emergency call in the community, they are trained to check whether the patient has a pink MOLST form before initiating life-sustaining treatment. They might not notice a MOLST form on plain white paper. However, white MOLST forms and photocopies, faxes, or electronic representations of the original, signed MOLST are legal and valid.

MOLST orders completed in accordance with New York law remain valid when the patient transitions from one health care setting to another. Non-hospital DNR orders must be reviewed by a physician or nurse practitioner at least every 90 days. In addition, all MOLST orders must be reviewed consistent with facility policy and when the patient transitions between care settings, when there is a major change in health status, and when the patient or other health care decision-maker changes his/her mind about treatment.

Decision-making standards, procedures and statutory witness requirements for decisions to withhold or withdraw life-sustaining treatment, including DNR, vary depending on who makes the decision and where the decision is made. Accordingly, there are different checklists for different types of decision-makers and settings.

Please note: <u>There are 5 different checklists for adult patients</u>:

<u>Checklist #1</u> - Adult patients with medical decision-making capacity (any setting)

<u>Checklist #2</u> - Adult patients without medical decision-making capacity who have a health care proxy (any setting)

<u>Checklist #3</u> - Adult hospital, hospice or nursing home patients without medical decision-making capacity who do not have a health care proxy, and decision-maker is Public Health Law Surrogate (surrogate selected from the surrogate list)

Checklist #4 - Adult hospital, hospice or nursing home patients without medical decision-making capacity who do not have a health care proxy and for whom no surrogate from the list is available

Checklist #5 - Adult patients without medical decision-making capacity who do not have a health care proxy, and the MOLST form is being completed in the community

Choose the correct checklist. Then, complete the clinical steps and legal requirements based on who makes the decision and the setting.

The checklists can be found on the Department of Health's website at: https://www.health.ny.gov/professionals/patients/patient_rights/molst/.

Review and Renewal of MOLST Orders

The physician or nurse practitioner must review the MOLST form from time to time as the law requires, and also:

- If the patient moves from one location to another to receive care; or
- If the patient has a major change in health status (for better or worse); or
- If the patient or other decision-maker changes his or her mind about treatment.

If the patient lacks capacity to make health care decisions, the Health Care Agent or Surrogate may request a change in the MOLST and must be consulted about any changes recommended by the patient's health care provider when any of the above circumstances arise.

DNR/Allow Natural Death orders: Public Health Law requires the physician or nurse practitioner to review non-hospital DNR orders and record the review at least **every 90 Days**. In hospitals and nursing homes, MOLST orders must be reviewed regularly in accordance with facility policies.

Life-Sustaining Treatment orders: The patient's medical condition, prognosis, values, wishes and goals for his/her care may change over time. The physician or nurse practitioner should review these orders at the same time as DNR/Allow Natural Death orders are reviewed and the review is recorded.

Review all medical orders in Sections A through E of the MOLST form.

Document the outcome of the review in Section F

- If there is no change in the patient's health status, medical decision-making capacity or preferences, sign, date and check the "No Change" box.

- If there is a substantial change in patient's health status, medical decision-making capacity, goals for care or preferences that results in a change in MOLST orders, write "VOID" in large letters on pages 1 and 2, and complete a new form, in accordance with NYS Public Health Law decision-making standards and procedures. Check box marked "FORM VOIDED, new form completed." (RETAIN voided MOLST form in chart, medical record, or electronic registry as required by law.)
- If this form is voided and no new form is completed, full treatment and resuscitation will be provided, unless a different decision is made by the patient, surrogate or health care agent. Write "VOID" in large letters on pages 1 and 2 and check box marked "FORM VOIDED, no new form." (RETAIN voided MOLST form in chart, medical record, or electronic registry as required by law.)

For more information about the MOLST Program, view the Department of Health's website at https://www.health.ny.gov/professionals/patients/patient_rights/molst/ and the Compassion and Support website, Professionals section and the MOLST Training Center at www.CompassionAndSupport.org.

Glossary

"Adult" means any person 18 or older or any person who has married.

"Clear and convincing evidence" is evidence that the patient held a firm and settled commitment to the withholding of life-sustaining treatment in the event of circumstances like the patient's current medical condition. The evidence may be in a written living will, and/or previous oral statements indicating the patient's wishes, considering the circumstances under which such statements were made and to whom. In order to decide whether the evidence of the patient's wishes is clear and convincing, consideration should be given to:

- whether the statements were general or specific;
- whether the statements were about specific circumstances (for example, terminal illness, persistent vegetative state) that are similar to the patient's current medical condition;
- the intensity, frequency, consistency, and seriousness of such statements;
- whether the statements tended to show that the patient held a firm and settled commitment to certain treatment decisions under circumstances like those presented;
- whether the strength and durability of the patient's religious and moral beliefs make a more recent change of heart unlikely; and
- whether the statements were made to one person only or to more than one person close to the patient.

"Close friend" is any person 18 or older who is a friend or relative of the patient. This person must have maintained regular contact with the patient; be familiar with the patient's activities,

health, and religious or moral beliefs; and present a signed statement to that effect to the attending doctor.

"Community" means not in a hospital, hospice or nursing home.

"Domestic partner" means a person who:

- has entered into a formal domestic partnership recognized by a local, state or national government; or
- has registered as a domestic partner with a registry maintained by the government or an employer; or
- is covered as a domestic partner under the same employment benefits or health insurance; or
- shares a mutual intent to be a domestic partner with the patient, considering all the facts and circumstances, such as:
  - They live together.
  - They depend on each other for support.
  - They share ownership (or a lease) of their home or other property.
  - They share income or expenses.
  - They are raising children together.
  - They plan on getting married or becoming formal domestic partners.
  - They have been together for a long time.

The following may not be a "domestic partner:"

- A parent, grandparent, child, grandchild, brother, sister, uncle, aunt, nephew or niece of the patient or the patient's spouse.
- A person who is younger than 18.

"Health or social service practitioner" means a registered professional nurse, nurse practitioner, physician, physician assistant, psychologist or licensed clinical social worker, licensed or certified pursuant to the Education Law and acting within his or her scope of practice. A health or social service practitioner who determines that a patient lacks medical decision-making capacity must be competent to do so, based on his/her experience and training.

"Hospital" means a general hospital as defined in subdivision ten of section twenty-eight hundred one of the Public Health Law, excluding a ward, wing, unit or other part of a general hospital operated for the purpose of providing services for persons with mental illness pursuant to an operating certificate issued by the New York State Office of Mental Health; or a hospice as defined in Public Health Law Article 40, without regard to where the hospice care is provided.

"Life-sustaining treatment" means any medical treatment or procedure without which the patient will die within a relatively short time, as determined by an attending physician or nurse practitioner to a reasonable degree of medical certainty. Cardiopulmonary resuscitation

(CPR) is presumed to be life-sustaining treatment without the necessity of a determination by an attending physician or nurse practitioner.

"Mental hygiene facility" means, for purposes of these checklists, a facility operated or licensed by the Office of Mental Health (OMH) or the Office for People With Developmental Disabilities (OPWDD) as defined in subdivision six of section 1.03 of the Mental Hygiene Law; i.e., any place in which services for the mentally disabled are provided and includes but is not limited to a psychiatric center, developmental center, institute, clinic, ward, institution or building, except that in the case of a hospital as defined in Article 28 of the Public Health Law it shall mean only a ward, wing, unit, or part thereof which is operated for the purpose of providing services for the mentally disabled. A mental hygiene facility also includes a community residence operated by or subject to licensure by OMH or OPWDD (MHL §1.03(28)).

"Nurse practitioner" means a licensed nurse practitioner.

"Nursing home" means a residential health care facility as defined in subdivision three of section twenty-eight hundred one of the Public Health Law.

"Physician" means a licensed physician.

"Qualified psychiatrist" means a physician licensed to practice medicine in New York State, who is a diplomate or eligible to be certified by the American Board of Psychiatry and Neurology or who is certified by the American Osteopathic Board of Neurology and Psychiatry or is eligible to be certified by that board.

"Reasonably available" means that a person to be contacted, can be contacted with diligent efforts by an attending physician or nurse practitioner, another person acting on behalf of an attending physician or nurse practitioner, or the hospital or nursing home.

MOLST LEGAL REQUIREMENTS CHECKLIST FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

_____ _____
LAST NAME/FIRST NAME DATE OF BIRTH

_____
ADDRESS

Note: Actual orders should be placed on the MOLST form with this completed checklist attached. Use of this checklist is required for individuals with developmental disabilities (DD) who lack the capacity to make their own health care decisions and do not have a health care proxy. Medical decisions which involve the withholding or withdrawing of life sustaining treatment (LST) for individuals with DD who lack capacity and do not have a health care proxy must comply with the process set forth in the Health Care Decisions Act for persons with MR (HCDA) [SCPA § 1750-b (4)]. Effective June 1, 2010, this includes the issuance of DNR orders.

Step 1 – Identification of Appropriate 1750-b Surrogate from Prioritized List. Check appropriate category and add name of surrogate.

_____ a. 17-A guardian _____
_____ b. actively involved spouse _____
_____ c. actively involved parent _____
_____ d. actively involved adult child _____
_____ e. actively involved adult sibling _____
_____ f. actively involved family member _____
_____ g. Willowbrook CAB (full representation)
_____ h. Surrogate Decision Making Committee (MHL Article 80)

Step 2 – 1750-b surrogate has a conversation or a series of conversations with the treating physician regarding possible treatment options and goals for care. Following these discussions, the 1750-b surrogate makes a decision to withhold or withdraw LST, either orally or in writing.

Specify the LST that is requested to be withdrawn or withheld: _____

_____

_____

_____ Decision made orally

_____ _____
Witness – Attending Physician Second Witness

_____ Decision made in writing (must be dated, signed by surrogate, signed by 1 witness and given to attending physician).

Revised 3/18/2013

_____ _____
LAST NAME/FIRST NAME DATE OF BIRTH

Step 3 – Confirm individual's lack of capacity to make health care decisions. Either the attending physician or the concurring physician or licensed psychologist must: (a) be employed by a DDSO; or (b) have been employed for at least 2 years in a facility or program operated, licensed or authorized by OPWDD; or (c) have been approved by the commissioner of OPWDD as either possessing specialized training or have 3 years experience in providing services to individuals with DD.

_____ _____
Attending Physician Concurring Physician or Licensed Psychologist

Step 4– Determination of Necessary Medical Criteria.

We have determined to a reasonable degree of medical certainty that **both** of the following conditions are met:

(1) the individual has one of the following medical conditions:

_____ a. a terminal condition; (briefly describe _____

_____); or

_____ b. permanent unconsciousness; or

_____ c. a medical condition other than DD which requires LST, is irreversible and which will continue indefinitely (briefly describe_____

_____)

AND

(2) the LST would impose an extraordinary burden on the individual in light of:

_____ a. the person's medical condition other than DD (briefly explain_____

_____) and

_____ b. the expected outcome of the LST, notwithstanding the person's DD (briefly explain _____

_____)

If the 1750-b surrogate has requested that artificially provided nutrition or hydration be withdrawn or withheld, one of the following additional factors must also be met:

_____ a. there is no reasonable hope of maintaining life (explain_____

_____); or

_____ b. the artificially provided nutrition or hydration poses an extraordinary burden (explain_____

_____

_____).

_____ _____
Attending Physician Concurring Physician

_____ _____
LAST NAME/FIRST NAME DATE OF BIRTH

Step 5 – Notifications. At least 48 hours prior to the implementation of a decision to withdraw LST, or at the earliest possible time prior to a decision to withhold LST, the attending physician must notify the following parties:

_____ the person with DD, unless therapeutic exception applies
notified on ___/___/___

_____ if the person is in or was transferred from an OPWDD residential facility

_____ Facility Director notified on ____/___/____

_____ MHLS notified on ____/___/____

_____ if the person is not in and was not transferred from an OPWDD residential facility

_____ the director of the local DDSO notified on ____/___/____

Step 6 - I certify that the 1750-b process has been complied with, the appropriate parties have been notified and no objection to the surrogate's decision remains unresolved.

_____ _____
Attending Physician Date

Note: The MOLST form may ONLY be completed with the 1750-b surrogate after all 6 steps on this checklist have been completed.

Checklist #1 Adult Patients with Medical Decision-Making Capacity (Any Setting)

Complete each step and check the appropriate lines as indicated.

Step 1: Assess health status and prognosis. ___

Step 2: Check all advance directives known to have been completed.

__ Health Care Proxy __ Living Will __ Organ Donation __ Documentation of Oral Advance Directive

Step 3: If there is no health care proxy, assess capacity to complete a health care proxy.
Any patient should be counseled to complete a health care proxy, if he/she has not already completed one.

Document the result of patient counseling, if applicable. ***Check one:***

___ Patient retains the capacity to choose a health care agent and completes a health care proxy.
___ Patient retains the capacity to choose a health care agent, but chooses not to complete a health care proxy.

Step 4: Determine the patient's medical decision-making capacity. *Check one:*

___ Patient has the ability to understand and appreciate the nature and consequences of *DNR and Life-Sustaining Treatment* orders, including the benefits and burdens of, and alternatives to, such orders, and to reach an informed decision regarding the orders.

(If the patient lacks medical decision-making capacity, go to Step 7 and select the appropriate checklist)

Step 5: Identify the decision-maker.

___ Patient is the decision-maker

Step 6: Document where the MOLST form is being completed. *Check one:*

___ Hospital (see Glossary for definition, includes hospice, regardless of setting)
___ Nursing Home (see Glossary for definition)
___ Community (see Glossary for definition)

Step 7: Be sure you have selected the appropriate legal requirements checklist, based on who makes the decision and the setting. *Check one:*
This is Checklist # 1 (for patients who have medical decision-making capacity). If this is the appropriate checklist, proceed to Step 8 below. If this is the wrong checklist, stop filling out this checklist; find and complete the correct checklist. All checklists can be found on the Department of Health's website at https://www.health.ny.gov/professionals/patients/patient_rights/molst/.

___ Checklist #1 - Adult patients with medical decision-making capacity (any setting)

___ Checklist #2 - Adult patients without medical decision-making capacity who have a health care proxy (any setting)

___ Checklist #3 - Adult hospital, hospice or nursing home patients without medical decision-making capacity who do not have a health care proxy, and decision-maker is Public Health Law Surrogate (surrogate selected from the surrogate list)

___ Checklist #4 - Adult hospital, hospice or nursing home patients without medical decision-making capacity who do not have a health care proxy and for whom no surrogate from the surrogate list is available

___ Checklist #5 - Adult patients without medical decision-making capacity who do not have a health care proxy, and MOLST form is being completed in the community

Step 8: Discuss goals for care with the patient. ___

Step 9: Patient has given informed consent.

___ Patient has been fully informed about his or her medical condition and the risks, benefits and burdens of, and alternatives to, possible life-sustaining treatment. Patient has consented to the withholding, withdrawal or delivery of certain life-sustaining treatment, for which medical orders are written.

Step 10: Witness requirements are met. *Check one:*

Two witnesses are always recommended. The physician or nurse practitioner who signs the orders may be a witness. To document that the attending physician or nurse practitioner witnessed the consent, the attending physician or nurse practitioner just needs to sign the order and print his/her name as a witness. Witness signatures are not required – printing the witnesses' names is sufficient.

___ Patient consented in writing.

___ Patient is in a hospital or nursing home, the patient consented verbally, and two witnesses 18 years of age or older (at least one of whom is a health or social services practitioner affiliated with the hospital or nursing home) witnessed the consent.

___ Patient is in the community, patient consented verbally, and the attending physician or nurse practitioner witnessed the consent.

Step 11: Physician or nurse practitioner signature

___ The attending physician or nurse practitioner signed the MOLST form.

Step 12: Notify director of correctional facility.

___ For adult patients who are inmates in, or are transferred from, a correctional facility, the attending physician or nurse practitioner has notified the director of the correctional facility of the determination that the inmate has medical decision-making capacity and that the inmate has MOLST orders.

Health Care Proxy (Any Setting)

A health care agent may make medical decisions on behalf of a patient, after two physicians/nurse practitioners concur that the patient lacks medical decision-making capacity. Health care agents are generally authorized to make decisions as if they were the patient. However, sometimes the patient's health care proxy limits the authority of the health care agent.

Health care agents are required to make decisions according to the patient's wishes, including the patient's religious and moral beliefs. If the patient's wishes are not reasonably known and cannot with reasonable diligence be ascertained, the health care agent may make decisions according to the patient's best interests, except a decision to withhold or withdraw artificial nutrition or hydration. Health care agents are authorized to make a decision to withhold or withdraw artificial nutrition or hydration only if they know the patient's wishes regarding the administration of artificial nutrition and hydration.

Complete each step and check the appropriate lines as indicated.

Step 1: Assess health status and prognosis. __

Step 2: Check all advance directives known to have been completed.

__ Health Care Proxy __ Living Will __ Organ Donation __ Documentation of Oral Advance Directive

Step 3: If there is no health care proxy, assess capacity to complete a health care proxy.

A patient who lacks the capacity to consent to medical orders for life-sustaining treatment may still have the capacity to choose a health care agent and complete a health care proxy. Any patient with that capacity should be counseled to complete a health care proxy, if he/she has not already completed one.

Document the result of patient counseling, if applicable. *Check one*:

___ Patient retains the capacity to choose a health care agent and completes a health care proxy.
___ Patient retains the capacity to choose a health care agent, but chooses not to complete a health care proxy.
___ Patient lacks capacity to choose a health care agent.

If there is no health care proxy, and patient chooses not to complete one or lacks capacity to do so, go to Step 8 and select the appropriate checklist. If there is a health care proxy, proceed to Step 4.

Step 4: Determine the patient's medical decision-making capacity. ***Check appropriate line(s) under (A) and (B) (if a required item cannot be checked because the patient has capacity, use Checklist #1 for adults with medical decision-making capacity.):***

(A) Attending Physician/Nurse Practitioner Determination *Check both:*

___ The attending physician or nurse practitioner has determined in writing to a reasonable degree of medical certainty that the patient lacks capacity to understand and appreciate the nature and consequences of *DNR and Life-Sustaining Treatment* orders, including the benefits and burdens of, and alternatives to, such orders, and to reach an informed decision regarding the orders.

___ The determination contains the attending physician or nurse practitioner's opinion regarding the cause and nature of the patient's incapacity as well as its extent and probable duration. The determination is documented in the patient's medical record.

Physician or Nurse Practitioner Determination *Check (i), (ii)* or *(iii)* and *all line(s) underneath:*

___ (i) The attending physician or nurse practitioner has determined that the patient's lack of medical decision-making capacity is *not due* to mental illness or a developmental disability; and

__ A concurring physician or nurse practitioner confirmed that the patient lacks medical decision-making capacity. Such determination is also included in the patient's medical record.

___ (ii) The attending physician or nurse practitioner has determined that the lack of medical decision-making capacity *is due* to mental illness (this does not include dementia); and *Check both*:

__ A concurring physician or nurse practitioner confirmed that the patient lacks medical decision-making capacity. Such determination is also included in the patient's medical record.

__ One of the two practitioners who determined that the patient lacks medical decision-making capacity is a physician who is a qualified psychiatrist. The determination by the qualified psychiatrist is documented in the medical record.

___ (iii) The attending physician or nurse practitioner has determined that the lack of medical decision-making capacity *is due* to a developmental disability; and *Check both*:

__ A concurring physician, nurse practitioner, or clinical psychologist confirmed that the patient lacks medical decision-making capacity. Such determination is also included in the patient's medical record.

__ The concurring physician, nurse practitioner, or clinical psychologist is employed by a Developmental Disabilities Services Office (DDSO), or has been employed for a minimum of two years to render care and service in a facility operated or licensed by the Office for People With Developmental Disabilities, or has specialized training and two years' experience treating persons with developmental disabilities or has three years' experience treating persons with developmental disabilities. The determination by the concurring physician, nurse practitioner, or clinical psychologist is documented in the medical record.

Step 5: Notify the patient *Check one:*

___ Notice of the determination that the patient lacks medical decision-making capacity has been given to the patient, orally and in writing (the patient may be able to comprehend such notice).

___ Notice of the determination that the patient lacks medical decision-making capacity has not been given to the patient, because there is no indication of the patient's ability to comprehend such notice.

Step 6: Identify the decision-maker:

__ The health care agent is the decision-maker.

Step 7: Document where the MOLST form is being completed. *Check one:*

___ Hospital (see Glossary for definition, includes hospice, regardless of setting)
___ Nursing Home (see Glossary for definition)
___ Community (see Glossary for definition)

Step 8: Be sure you have selected the appropriate legal requirements checklist, based on who makes the decision and the setting. *Check one:*

This is Checklist # 2 (for adults without medical decision-making capacity who have a health care proxy). If this is the appropriate checklist, proceed to Step 9 below. If this is the wrong checklist, stop filling out this checklist; find

https://www.health.ny.gov/professionals/patients/patient_rights/molst/

___ Checklist #1 - Adult patients with medical decision-making capacity (any setting)

___ Checklist #2 - Adult patients without medical decision-making capacity who have a health care proxy (any setting)

___ Checklist #3 - Adult hospital, hospice or nursing home patients without medical decision-making capacity who do not have a health care proxy, and decision-maker is Public Health Law surrogate (surrogate selected from the surrogate list)

___ Checklist #4 - Adult hospital, hospice or nursing home patients without medical decision-making capacity who do not have a health care proxy and for whom no surrogate from the surrogate list is available

___ Checklist #5 - Adult patients without medical decision-making capacity who do not have a health care proxy, and MOLST form is being completed in the community

Step 9: Discuss goals for care with the health care agent. ___

Step 10: Health care agent has given informed consent.

___
- Health care agent has been fully informed about the patient's medical condition and the risks, benefits, burdens and alternatives of possible life-sustaining treatment.
- Health care agent has consented to the withholding, withdrawal or delivery of certain life-sustaining treatment, for which medical orders are written.
- If health care agent is consenting to withholding or withdrawing artificial nutrition or hydration, health care agent knows the patient's wishes regarding the administration of artificial nutrition and hydration (this may be presumed if the health care proxy states that the health care agent knows the patient's wishes regarding the administration of artificial nutrition and hydration).

Step 11: Witness requirements are met. *Check one:*

Two witnesses are always recommended. The physician or nurse practitioner who signs the orders may be a witness. To document that the attending physician or nurse practitioner has witnessed the consent, the attending physician or nurse practitioner just needs to sign the order and print his/her name as a witness. Witness signatures are not required – printing the witnesses' names is sufficient.

___ Health care agent has consented in writing.

___ Patient is in a hospital or nursing home, the health care agent consented verbally, and two witnesses 18 years of age or older, at least one of whom is a health or social services practitioner affiliated with the hospital or nursing home, have witnessed the consent.

___ Patient is in the community, health care agent has consented verbally and the attending physician or nurse practitioner has witnessed the consent.

Step 12: Physician or nurse practitioner signature

___ The attending physician or nurse practitioner has signed the MOLST form.

Step 13: Notify director of correctional facility.

___ For adult patients who are inmates in, or are transferred from, a correctional facility, the attending physician or nurse practitioner has notified the director of the correctional facility of the determination that the inmate lacks medical decision-making capacity and that the inmate has MOLST orders.

Checklist #3: Adult Hospital, Hospice or Nursing Home Patients Without Medical Decision-Making Capacity Who Do Not Have a Health Care Proxy, and Decision-Maker is Public Health Law Surrogate (a surrogate selected from the surrogate list)

Under the Family Health Care Decisions Act, a surrogate selected from the surrogate list can make any kind of medical decision in a hospital, hospice or nursing home, after the attending physician or nurse practitioner and another health or social services practitioner at the facility concur that the patient lacks capacity. For decisions to withhold or withdraw life-sustaining treatment, specific clinical criteria must be satisfied. Sometimes, the facility's ethics review committee must agree.

Complete each step and check the appropriate lines as indicated.

Step 1: Assess health status and prognosis. ___

Step 2: Check all advance directives known to have been completed.

___ Health Care Proxy ___ Living Will ___ Organ Donation ___ Documentation of Oral Advance Directive
(If there is a health care proxy, and the health care agent can make the decision, stop filling out this checklist. Use Checklist #2 for adults with a health care proxy.)

Step 3: If there is no health care proxy, assess capacity to complete a health care proxy.

A patient who lacks the capacity to consent to medical orders for life-sustaining treatment may still have the capacity to choose a health care agent and complete a health care proxy. Any patient with that capacity should be counseled to complete a health care proxy, if he/she has not already completed one.

Document the result of patient counseling. ***Check one:***

___ Patient retains the capacity to choose a health care agent and completes a health care proxy. (If the patient completes a health care proxy, use Checklist #2 for adults with a health care proxy).
___ Patient retains the capacity to choose a health care agent, but chooses not to complete a health care proxy.
___ Patient lacks capacity to choose a health care agent.

Step 4: Determine the patient's medical decision-making capacity. *Check appropriate lines under (A) and (B) (if a required item cannot be checked because the patient has capacity, use Checklist #1 for patients with capacity.):*

(A) Attending Physician or Nurse Practitioner Determination ***Check both:***

___ The attending physician or nurse practitioner has determined in writing to a reasonable degree of medical certainty that the patient lacks capacity to understand and appreciate the nature and consequences of *DNR and Life-Sustaining Treatment* orders, including the benefits and burdens of, and alternatives to, such orders, and to reach an informed decision regarding the orders.

___ The determination contains the attending physician's or nurse practitioner's assessment of the cause and extent of the patient's incapacity and the likelihood that the patient will regain medical decision-making capacity. The determination is documented in the patient's medical record.

(B) Assessment for Mental Illness and Concurring Determination ***Check (i) or (ii) and all line(s) underneath:***

___ (i) The attending physician or nurse practitioner has determined that the patient's lack of medical decision-making capacity is ***not*** *due* to mental illness; and

___ A health or social services practitioner employed by, or formally affiliated with, the facility has independently determined that the patient lacks medical decision-making capacity. The concurring determination includes an assessment of the cause and extent of the patient's incapacity and the

likelihood that the patient will regain medical decision-making capacity. Such determination is also included in the patient's medical record.

___ (ii) The attending physician or nurse practitioner has determined that the lack of medical decision-making capacity ***is due*** to mental illness (this does not include dementia); and ***Check both***:

___ A health or social services practitioner employed by, or formally affiliated with, the facility has independently determined that the patient lacks medical decision-making capacity. The concurring determination includes an assessment of the cause and extent of the patient's incapacity and the likelihood that the patient will regain medical decision-making capacity. Such determination is also included in the patient's medical record.

___ Either the attending physician or the health or social services practitioner who determined that the patient lacks medical decision-making capacity is a qualified psychiatrist. The determination by the qualified psychiatrist is documented in the medical record.

Step 5: Notify the patient. ***Check one:***

___ Notice of the determination that the patient lacks medical decision-making capacity and that a surrogate will make medical decisions on his/her behalf has been given to the patient (the patient may be able to comprehend such notice).

___ Notice of the determination that the patient lacks medical decision-making capacity and that a surrogate will make decisions on his/her behalf has not been given to the patient because there is no indication of the patient's ability to comprehend the information.

Step 6: Identify and notify the appropriate Public Health Law surrogate. ***Check both:***

___ The attending physician or nurse practitioner has identified a person **from the class highest in priority** who is reasonably available, willing, and competent to serve as a surrogate decision-maker. Such person may designate any other person on the list to be surrogate, provided no one in a class higher in priority than the person designated objects. ***Check one:***

___ a. Patient's guardian authorized to decide about health care pursuant to Mental Hygiene Law Article 81
___ b. Patient's spouse, if not legally separated from the patient, or the domestic partner
___ c. Patient's son or daughter, age 18 or older
___ d. Patient's parent
___ e. Patient's brother or sister, age 18 or older
___ f. Patient's actively involved close friend, age 18 or older

___ The attending physician or nurse practitioner has notified at least one person on the surrogate list who is highest in order of priority, and who is reasonably available, that he/she will make medical decisions because the patient has been determined to lack medical decision-making capacity.

Step 7: Document where the MOLST form is being completed. ***Check one:***

___ Hospital (see Glossary for definition, includes hospice, regardless of setting)
___ Nursing Home (see Glossary for definition)

Step 8: Be sure you have selected the appropriate legal requirements checklist, based on who makes the decision and the setting. ***Check one:***

This is Checklist # 3 (for adult hospital, hospice or nursing home patients without medical decision-making capacity who do not have a health care proxy, and whose decision-maker is a Public Health Law surrogate). If this is the appropriate checklist, proceed to Step 9 below. If this is the wrong checklist, find and complete the correct checklist. All checklists

can be found on the Department of Health's website at
https://www.health.ny.gov/professionals/patients/patient_rights/molst/

___ Checklist #1 - Adult patients with medical decision-making capacity (any setting)

___ Checklist #2 - Adult patients without medical decision-making capacity who have a health care proxy (any setting)

___ Checklist #3 - Adult hospital, hospice or nursing home patients without medical decision-making capacity who do not have a health care proxy, and decision-maker is Public Health Law Surrogate (surrogate selected from the surrogate list)

___ Checklist #4 - Adult hospital, hospice or nursing home patients without medical decision-making capacity who do not have a health care proxy and for whom no surrogate from the surrogate list is available

___ Checklist #5 - Adult patients without medical decision-making capacity who do not have a health care proxy, and MOLST form is being completed in the community

Step 9: Discuss goals for care with the Public Health Law surrogate. ___

Step 10: Surrogate has given informed consent. ***Check all:***

___ Surrogate has been fully informed about the patient's medical condition and the risks, benefits, burdens and alternatives of possible life-sustaining treatment.

___ Surrogate has consented to the withholding, withdrawal or delivery of certain life-sustaining treatment, for which medical orders are written.

___ Surrogate's decision is *patient-centered*, in accordance with the patient's wishes, including the patient's religious and moral beliefs; or if the patient's wishes are not reasonably known and cannot with reasonable diligence be ascertained, in accordance with the patient's best interests. The surrogate's assessment is based on the patient's wishes and best interests, not the surrogate's, and includes consideration of:

- the dignity and uniqueness of every person;
- the possibility and extent of preserving the patient's life;
- the preservation, improvement or restoration of the patient's health or functioning;
- the relief of the patient's suffering; and
- any medical condition and such other concerns and values as a reasonable person in the patient's circumstances would wish to consider.

Step 11: If the decision is to withhold or withdraw life sustaining treatment, the surrogate's decision complies with the following clinical standards, as determined by the physician or nurse practitioner, with independent physician or nurse practitioner concurrence and, where applicable, by an ethics review committee. ***Check (i) and/or (ii) and (iii) and any applicable lines underneath:***

__ (i) Treatment would be an extraordinary burden to the patient, **and** an attending physician or nurse practitioner determines, with the independent concurrence of another physician or nurse practitioner, that, to a reasonable degree of medical certainty and in accord with accepted medical standards,

- the patient has an illness or injury which can be expected to cause death within six months, whether or not treatment is provided; **or**
- the patient is permanently unconscious.

__ (ii) The provision of treatment would involve such pain, suffering or other burden that it would reasonably be deemed inhumane or extraordinarily burdensome under the circumstances; **and** the patient has an irreversible or incurable condition, as determined by an attending physician or nurse practitioner with the independent concurrence of another physician or nurse practitioner to a reasonable degree of medical certainty and in accordance with accepted medical standards.

__ **Special requirements for declining artificial nutrition and hydration in a hospital over the attending physician's or nurse practitioner's objection, and for certain life sustaining treatments in a nursing home, based on "irreversible or incurable condition" (clinical standard (ii) above)**
Note – These requirements do not apply to a decision for a patient in hospice or to a decision to withhold or withdraw life-sustaining treatment under clinical standard (i) above (death is expected within 6 months with or without treatment, or patient is permanently unconscious):

__ In a hospital (other than a hospice), when the medical order involves the withdrawal or withholding of nutrition or hydration provided by means of medical treatment, and the attending physician or nurse practitioner objects to the order, the ethics review committee (including a physician or nurse practitioner who is not directly responsible for the patient's care) or an appropriate court has determined that the medical order meets the patient-centered and clinical standards.

__ In a nursing home, for MOLST orders other than a DNR order, the ethics review committee, (including at least one physician or nurse practitioner who is not directly responsible for the patient's care) or an appropriate court has determined that the orders meet the patient-centered and clinical standards described above.

__ (iii) The concurring physician's or nurse practitioner's determination is documented in the medical record.

Step 12: Witness requirements are met. *Check one:*

Two witnesses are always recommended. The physician or nurse practitioner who signs the orders may be a witness. To document that the attending physician or nurse practitioner witnessed the consent, the attending physician or nurse practitioner signs the order and prints his/her name as a witness. Witness signatures are not required – printing the witnesses' names is sufficient.

__ The surrogate consented in writing.

__ The surrogate consented verbally, and the attending physician or nurse practitioner witnessed the consent.

Step 13: If the surrogate is a close friend, verify the age and relationship with the patient.

__ The surrogate is 18 or older and has signed a statement that he or she is a close friend of the patient, or a relative of the patient (other than a spouse, adult child, parent, brother or sister), who has maintained such regular contact with the patient as to be familiar with the patient's activities, health, and religious or moral beliefs. A copy of the signed statement is in the medical record.

Step 14: Physician or nurse practitioner signature

__ The attending physician or nurse practitioner signed the MOLST form.

Step 15: Notify director of mental hygiene facility and Mental Hygiene Legal Services (MHLS).

___ For patients who are residents in, or are transferred from, a mental hygiene facility, the attending physician or nurse practitioner has notified the director of the facility and MHLS of the determination that the resident lacks medical decision-making capacity and that the resident has MOLST orders.

Step 16: Notify director of correctional facility.

___ For adult patients who are inmates in, or are transferred from, a correctional facility, the attending physician or nurse practitioner has notified the director of the correctional facility of the determination that the inmate lacks medical decision-making capacity and that the inmate has MOLST orders.

Checklist #4 Adult hospital, hospice or nursing home patients without medical decision-making capacity who do not have a health care proxy and for whom no surrogate from the surrogate list is available

Under the Family Health Care Decisions Act, a patient who lacks capacity and who does not have a health care agent or surrogate may be enrolled in hospice with a plan of care that includes orders regarding the provision or withdrawal/withholding of life-sustaining treatment, if two physicians or nurse practitioners and an Ethic Review Committee agree that the patient meets certain criteria (which are the same criteria that would apply to a decision by a surrogate under Checklist 3).

This checklist may also be used for a life-sustaining treatment decision for a patient who is already enrolled in hospice.

If the patient is not enrolled in Hospice, life-sustaining treatment may be withheld from a patient in a hospital or nursing home who does not have a health care proxy or a surrogate, only if a court makes the decision or two physicians or nurse practitioners authorized by the facility concur that the patient would die imminently, even if the patient received the treatment, and that provision of the treatment would violate accepted medical standards.

Complete each step and check the appropriate lines as indicated.

Step 1: Assess health status and prognosis. ___

Step 2: Check all advance directives known to have been completed.

___ Health Care Proxy ___ Living Will ___ Organ Donation ___ Documentation of Oral Advance Directive
(If there is a health care proxy and the health care agent can make the decision, stop filling out this checklist. Use Checklist #2 for adults with a health care proxy.)

Step 3: If there is no health care proxy, assess capacity to complete a health care proxy.

A patient who lacks the capacity to consent to medical orders for life-sustaining treatment may still have the capacity to choose a health care agent and complete a health care proxy. Any patient with that capacity should be counseled to complete a health care proxy, if he/she has not already completed one.

Document the result of patient counseling, if applicable. **Check one:**

___ Patient retains the capacity to choose a health care agent and completes a health care proxy. (If the patient completes a health care proxy, use Checklist #2 for adults with a health care proxy).
___ Patient retains the capacity to choose a health care agent, but chooses not to complete a health care proxy.
___ Patient lacks capacity to choose a health care agent.

Step 4: Determine the patient's medical decision-making capacity. *Check appropriate lines under (A) and (B) (if a required item cannot be checked because the patient has capacity, use Checklist #1 for patients with capacity.):*

(A) **Attending Physician/Nurse Practitioner Determination** (check both)
___ The attending physician or nurse practitioner has determined in writing to a reasonable degree of medical certainty that the patient lacks the ability to understand and appreciate the nature and

consequences of DNR and Life-Sustaining Treatment orders, including benefits and burdens of and alternatives to such orders, and to reach an informed decision regarding the orders.

___ The determination contains the attending physician's/nurse practitioner's assessment of the cause and extent of the patient's incapacity and the likelihood that the patient will regain medical decision-making capacity. The determination is documented in the patient's medical record.

(B) Assessment for Mental Illness and Concurring Determination *Check (i) or (ii) and all line(s) underneath:*

___ (i) The attending physician or nurse practitioner has determined that the patient's lack of medical decision-making capacity is not due to mental illness; and

___ A health or social services practitioner employed by, or formally affiliated with, the facility has independently determined that the patient lacks medical decision-making capacity. The concurring determination includes an assessment of the cause and extent of the patient's incapacity and the likelihood that the patient will regain medical decision-making capacity. Such determination is also included in the patient's medical record.

___ (ii) The attending physician or nurse practitioner has determined that the lack of medical decision-making capacity is due to mental illness (this does not include dementia); and Check both:

___ A health or social services practitioner employed by, or formally affiliated with, the facility has independently determined that the patient lacks medical decision-making capacity. The concurring determination includes an assessment of the cause and extent of the patient's incapacity and the likelihood that the patient will regain medical decision-making capacity. Such determination is also included in the patient's medical record.

___ Either the attending physician or the health or social services practitioner who determined that the patient lacks medical decision-making capacity is a qualified psychiatrist. The determination by the qualified psychiatrist is documented in the medical record.

Step 5: Notify the Patient. *Check one:*

___ Notice of the determination that the patient lacks medical decision-making capacity has been given to the patient (the patient may be able to comprehend such notice).

___ Notice of the determination that the patient lacks medical decision-making capacity has not been given to the patient, because there is no indication of the patient's ability to comprehend the information

Step 6: Determine that there is no Public Health Law Surrogate. *Check both:*

___ The attending physician or nurse practitioner, or someone acting on behalf of the attending physician or nurse practitioner, or the hospital or nursing home, made diligent efforts to contact a surrogate from the list below:

a. Patient's guardian authorized to decide about health care pursuant to Mental Hygiene Law Article 81
b. Patient's spouse, if not legally separated from the patient, or the domestic partner
c. Patient's son or daughter, age 18 or older
d. Patient's parent
e. Patient's brother or sister, age 18 or older
f. Patient's close friend, age 18 or older

___ No surrogate was reasonably available, willing and competent to make medical decisions for the patient.

Step 7: Document where the MOLST form is being completed. ***Check one:***

___ Hospital (see Glossary for definition)
___ Nursing Home (see Glossary for definition)
___ Hospice (i.e. for a patient already enrolled in hospice) (see Glossary for definition)

Step 8: Be sure you have selected the appropriate legal requirements checklist, based on who makes the decision and the setting. ***Check one:***

This is Checklist #4 for adult hospital or nursing home patients without medical decision-making capacity who do not have a health care proxy and for whom no surrogate from the surrogate list is available. If this is the appropriate checklist, proceed to Step 9 below. If this is the wrong checklist, stop filling out this checklist; find and complete the correct checklist. All checklists can be found on the Department of Health's website at http://www.nyhealth.gov/professionals/patients/patient_rights/molst/.

___ Checklist #1 - Adult patients with medical decision-making capacity (any setting)

___ Checklist #2 - Adult patients without medical decision-making capacity who have a health care proxy (any setting)

___ Checklist #3 - Adult hospital, hospice or nursing home patients without medical decision-making capacity who do not have a health care proxy, and decision-maker is Public Health Law Surrogate (surrogate selected from the surrogate list)

___ Checklist #4 - Adult hospital, hospice or nursing home patients without medical decision-making capacity who do not have a health care proxy and for whom no surrogate from the surrogate list is available

___ Checklist #5 - Adult patients without medical decision-making capacity who do not have a health care proxy, and MOLST form is being completed in the community

Step 9: Identify patient goals for care based on patient's wishes, if known, or patient's best interests ___

Step 10: Consult with staff directly responsible for the patient's care ___

Step 11: Decision complies with the following patient-centered standards as determined by the physician or nurse practitioner with independent physician or nurse practitioner concurrence:

___ Decision is patient-centered, in accordance with the patient's wishes, including the patient's religious and moral beliefs; or if the patient's wishes are not reasonably known and cannot with reasonable diligence be ascertained, in accordance with the patient's best interests. This assessment is assessment is based on the patient's wishes and best interests, not the decision-maker's, and includes consideration of:

- the dignity and uniqueness of every person;
- the possibility and extent of preserving the patient's life;

- the preservation, improvement or restoration of the patient's health or functioning;
- the relief of the patient's suffering; and
- any medical condition and such other concerns and values as a reasonable person in the patient's circumstances would wish to consider.

Step 12 Decision complies with the following clinical standards as determined by the physician or nurse practitioner with independent physician or nurse practitioner concurrence. ***Check (i) and/or (ii), and (iii):***

__ (i) Treatment would be an extraordinary burden to the patient, and an attending physician/nurse practitioner determines, with the independent concurrence of another physician/nurse practitioner, that, to a reasonable degree of medical certainty and in accord with accepted medical standards,

- the patient has an illness or injury which can be expected to cause death within six months, whether or not treatment is provided; or
- the patient is permanently unconscious.

__ (ii) The provision of treatment would involve such pain, suffering or other burden that it would reasonably be deemed inhumane or extraordinarily burdensome under the circumstances; and the patient has an irreversible or incurable condition, as determined by an attending physician/nurse practitioner with the independent concurrence of another physician/nurse practitioner to a reasonable degree of medical certainty and in accordance with accepted medical standards.

__ (iii) The decision was made in a general hospital or nursing home; or, if the decision was not made in a general hospital or nursing home, the concurring opinion was made by a physician.

Step 13: Ethics Review Committee:

___An Ethics Review Committee, composed as described below, reviewed the decision and determined that it was consistent with the standards in Steps 11 and 12:

- At least five members who have demonstrated an interest in or commitment to patient's rights or to the medical, public health, or social needs of those who are ill.
- At least three Ethics Review Committee members must be health or social services practitioners, at least one of whom must be a registered nurse and one of whom must be a physician or nurse practitioner.
- At least one member must be a person without any governance, employment or contractual relationship with the hospital.
- In a residential health care facility the facility must offer the residents' council the opportunity to appoint up to two persons to the Ethics Review Committee, none of whom may be a resident of or a family member of a resident of such facility, and both of whom shall be persons who have expertise in or a demonstrated commitment to patient rights or to the care and treatment of the elderly or nursing home residents through professional or community activities, other than activities performed as a health care provider

_____ The concurring physician/nurse practitioner's determination is documented in the medical record.

_____ The Ethics Review Committee determination is documented in the medical record.

Step 15: Physician/nurse practitioner signature

___ The attending physician/nurse practitioner has signed the MOLST form.

Step 16: Notify director of mental hygiene facility and Mental Hygiene Legal Services (MHLS).

___ For patients who are residents in, or are transferred from, a mental hygiene facility, the attending physician/nurse practitioner has notified the director of the facility and MHLS of the determination that the resident lacks medical decision-making capacity and, that there is no surrogate or health care proxy and that the resident has MOLST orders.

Step 17: Notify director of correctional facility.

___ For adult patients who are inmates in, or are transferred from, a correctional facility, the attending physician/nurse practitioner has notified the director of the correctional facility of the determination that the inmate lacks medical decision-making capacity, that there is no surrogate or health care proxy and that the inmate has MOLST orders.

Checklist #5: Adult Patients Without Medical Decision-Making Capacity Who Do Not Have a Health Care Proxy, and MOLST Form is Being Completed in the Community

In the community, Public Health Law surrogates (surrogates selected from the surrogate list) can consent to a nonhospital DNR order or a nonhospital DNI order, on behalf of patients who lack medical decision-making capacity. If MOLST is being completed in the community for a patient who does not have a health care proxy, the physician or nurse practitioner may issue medical orders to withhold life-sustaining treatment – other than DNR and DNI – only if there is clear and convincing evidence of the patient's wishes to refuse the treatment (see Glossary for definition of "clear and convincing evidence").

Complete each step and check the appropriate lines as indicated.

Step 1: Assess health status and prognosis. ___

Step 2: Check all advance directives known to have been completed.

___ Health Care Proxy ___ Living Will ___ Organ Donation ___ Documentation of Oral Advance Directive
(If there is a health care proxy and the health care agent can make the decision, stop filling out this checklist. Use Checklist #2 for adults with a health care proxy).

Step 3: If there is no health care proxy, assess capacity to complete a health care proxy.

A patient who lacks the capacity to consent to medical orders for life-sustaining treatment may still have the capacity to choose a health care agent and complete a health care proxy. Any patient with that capacity should be counseled to complete a health care proxy, if he/she has not already completed one.

Document the result of patient counseling. *Check one*:

___ Patient retains the capacity to choose a health care agent and completes a health care proxy. (If the patient completes a health care proxy, use Checklist #2 for adults with a health care proxy.)
___ Patient retains the capacity to choose a health care agent, but chooses not to complete a health care proxy.
___ Patient lacks capacity to choose a health care agent.

Step 4: Determine the patient's medical decision-making capacity. *Check appropriate lines under (A) and (B) (if a required item cannot be checked because the patient has capacity, use Checklist #1 for patients with capacity.):*

(A) Attending Physician or Nurse Practitioner Determination *Check both:*

___ The attending physician or nurse practitioner has determined in writing to a reasonable degree of medical certainty that the patient lacks capacity to understand and appreciate the nature and consequences of *DNR and Life-Sustaining Treatment orders*, including the benefits and burdens of, and alternatives to, such orders, and to reach an informed decision regarding the orders.

___ The determination contains the attending physician's or nurse practitioner's assessment the cause and extent of the patient's incapacity and the likelihood that the patient will regain medical decision-making capacity. The determination is documented in the patient's medical record.

(B) Assessment for Mental Illness and Concurring Determination *Check (i) or (ii) and all line(s) underneath:*

___ (i) The attending physician or nurse practitioner has determined that the patient's lack of medical decision-making capacity is ***not*** *due* to mental illness; and

___ A health or social services practitioner has independently determined that the patient lacks medical decision-making capacity. The concurring determination includes an assessment of the cause and extent of the patient's incapacity and the likelihood that the patient will regain medical decision-making capacity. Such determination is also included in the patient's medical record.

___ (ii) The attending physician or nurse practitioner has determined that the lack of medical decision-making capacity ***is due*** to mental illness (this does not include dementia); and *Check both:*

___ A health or social services practitioner has independently determined that the patient lacks medical decision-making capacity. The concurring determination includes an assessment of the cause and extent of the patient's incapacity and the likelihood that the patient will regain medical decision-making capacity. Such determination is also included in the patient's medical record.

___ Either the attending physician or the health or social services practitioner who determined that the patient lacks medical decision-making capacity is a qualified psychiatrist. The determination by the qualified psychiatrist is documented in the medical record.

Step 5: Notify the patient. *Check one:*

___ Notice of the determination that the patient lacks medical decision-making capacity, and that any decision to issue a DNR or DNI order will be made by a surrogate, has been given to the patient (the patient may be able to comprehend such notice).

___ Notice of the determination that the patient lacks medical decision-making capacity, and that any decision to issue a DNR or DNI order will be made by a surrogate, has not been given to the patient, because there is no indication of the patient's ability to comprehend the information.

Step 6: Identify and notify the appropriate Public Health Law surrogate for DNR/DNI order. Check *both:*

___ The attending physician or nurse practitioner has identified a person **from the class highest in priority** who is reasonably available, willing, and competent to serve as a surrogate decision-maker. Such person may designate any other person on the list to be surrogate, provided no one in a class higher in priority than the person designated objects. *Check one:*

___ a. Patient's guardian authorized to decide about health care pursuant to Mental Hygiene Law Article 81
___ b. Patient's spouse, if not legally separated from the patient, or the domestic partner
___ c. Patient's son or daughter, age 18 or older
___ d. Patient's parent
___ e. Patient's brother or sister, age 18 or older
___ f. Patient's actively involved close friend, age 18 or older

___ The attending physician or nurse practitioner has notified at least one person on the surrogate list **highest in order of priority** who is reasonably available that he/she will make health care decisions related to DNR and/or DNI orders because the patient has been determined to lack medical decision-making capacity.

Step 7: Document where the MOLST form is being completed. *Check one:*

___ Community (see Glossary for definition)

Step 8: Be sure you have selected the appropriate legal requirements checklist, based on who makes the decision and the setting. *Check one:*

This is checklist #5 for adults without medical decision-making capacity in the community, who do not have a health care proxy. If this is the appropriate checklist, proceed to Step 9 below. If this is the wrong checklist, find and complete the correct checklist. All checklists can be found on the Department of Health's website at https://www.health.ny.gov/professionals/patients/patient_rights/molst/.

___ Checklist #1 - Adult patients with medical decision-making capacity (any setting)

___ Checklist #2 - Adult patients without medical decision-making capacity who have a health care proxy (any setting)

___ Checklist #3 - Adult hospital, hospice or nursing home patients without medical decision-making capacity who do not have a health care proxy, and decision-maker is Public Health Law Surrogate (surrogate selected from the surrogate list)

___ Checklist #4 - Adult hospital, hospice or nursing home patients without medical decision-making capacity who do not have a health care proxy and for whom no surrogate from the surrogate list is available

___ Checklist #5 - Adult patients without medical decision-making capacity who do not have a health care proxy, and MOLST form is being completed in the community

Step 9: Discuss goals for care with the Public Health Law surrogate. ___

Step 10: For DNR and/or DNI orders, surrogate has given informed consent ***Check all:***

___ Surrogate has been fully informed about the patient's medical condition and the risks, benefits, burdens and alternatives of possible life-sustaining treatment.
___ Surrogate has consented to the DNR and/or DNI orders.
___ Surrogate's decision is *patient-centered*, in accordance with the patient's wishes, including the patient's religious and moral beliefs; or if the patient's wishes are not reasonably known and cannot with reasonable diligence be ascertained, in accordance with the patient's best interests. The surrogate's assessment is based on the patient's wishes and best interests, not the surrogate's, and includes consideration of:

- the dignity and uniqueness of every person;
- the possibility and extent of preserving the patient's life;
- the preservation, improvement or restoration of the patient's health or functioning;
- the relief of the patient's suffering; and
- any medical condition and such other concerns and values as a reasonable person in the patient's circumstances would wish to consider.

Step 11: Surrogate's DNR and/or DNI decision complies with clinical standards, as determined by the physician or nurse practitioner with independent physician or nurse practitioner concurrence ***Check (i) and/or (ii) and (iii):***

___ (i) CPR and/or intubation would be an extraordinary burden to the patient **and** an attending physician or nurse practitioner determines, with the independent

concurrence of another physician or nurse practitioner, that, to a reasonable degree of medical certainty and in accord with accepted medical standards,

- the patient has an illness or injury which can be expected to cause death within six months, whether or not treatment is provided; **or**
- the patient is permanently unconscious.

___ (ii) The provision of CPR and/or intubation would involve such pain, suffering or other burden that it would reasonably be deemed inhumane or extraordinarily burdensome under the circumstances, **and** the patient has an irreversible or incurable condition, as determined by an attending physician or nurse practitioner with the independent concurrence of another physician or nurse practitioner to a reasonable degree of medical certainty and in accord with accepted medical standards.

___ (iii) The concurring physician's or nurse practitioner's determination is documented in the medical record.

Step 12: For medical orders other than DNR and DNI, secure and document "clear and convincing evidence" of the patient's wishes. (If only DNR and/or DNI orders are entered on the form, go to Step 13.) ***Check all:***

___ There is clear and convincing evidence (see Glossary for definition) of the patient's wishes, the evidence has been documented, and the documentation is in the medical record.

___ The Public Health Law surrogate has been notified and has been given an opportunity to present any additional evidence.

___ Check the "Based on clear and convincing evidence of patient's wishes" box in addition to the "Public Health Law Surrogate" box, if a medical order other than DNR and DNI is being issued based on clear and convincing evidence of the patient's wishes.

Step 13: Witness requirements are met. ***Check one:***

Two witnesses are always recommended. The physician or nurse practitioner who signs the orders may be a witness. To document that the attending physician or nurse practitioner witnessed the consent, the attending physician or nurse practitioner just needs to sign the order and print his/her name as a witness. Witness signatures are not required – printing the witnesses' names is sufficient.

___ The surrogate consented in writing.

___ The surrogate consented verbally, and the attending physician or nurse practitioner witnessed the consent.

Step 14: If the surrogate is a close friend, verify the age and relationship with the patient.

___ The surrogate is 18 or older and has signed a statement that he or she is a close friend of the patient, or a relative of the patient (other than a spouse, adult child, parent, brother or sister), who has maintained such regular contact with the patient as to be familiar with the patient's activities, health, and religious or moral beliefs. A copy of the signed statement is in the medical record.

Step 15: Physician or Nurse Practitioner Signature

___ The attending physician or nurse practitioner has signed the MOLST form.

Step 16: Notify Director of Correctional Facility.

___ For adult patients who are inmates in, or are transferred from, a correctional facility, the attending physician or nurse practitioner has notified the director of the correctional facility of the determination that the inmate lacks medical decision-making capacity and the inmate has MOLST orders.

Appendix D

Do Not Resuscitate Order

NEW YORK STATE DEPARTMENT OF HEALTH

Nonhospital Order Not to Resuscitate (DNR Order)

Person's Name: _____

Date of Birth: _____

Do not resuscitate the person named above.

*Physician's or Nurse Practitioner's Signature: _____

Print Name: _____

License Number: _____

Date: _____

It is the responsibility of the physician or nurse practitioner to determine, at least every 90 days, whether this order continues to be appropriate, and to indicate this by a note in the person's medical chart. The issuance of a new form is NOT required, and under the law this order should be considered valid unless it is known that it has been revoked. This order remains valid and must be followed, even if it has not been reviewed within the 90-day period.

*For individuals with an Intellectual or Developmental Disability (I/DD), the non-hospital DNR **must** be signed by a physician.

For individuals with an I/DD who do not have capacity and do not have a health care proxy, the physician must ensure compliance with SCPA Section 1750-b.

DOH-3474 (12/18)

Estado de Nueva York
Departamento de Salud

Orden para no resucitar fuera del hospital
(Orden de DNR - Do not resuscitate)

Nombre de la persona _____

Fecha de nacimiento __ / __ / __

No resucitar a la persona nombrada más arriba.

Firma del médico _____

Nombre en letra de molde_____

Número de licencia_____

Fecha __ / __ / __

El médico tiene la responsabilidad de determinar, por lo menos cada 90 días, si esta orden todavía es pertinente, e indicar esto con una nota en la historia clínica del individuo. NO es necesario emitir un formulario nuevo, y según la ley, esta orden se debe considerar válida a menos que se sepa que fue anulada. Esta orden permanece en vigencia y se debe obedecer, aunque no haya sido revisada dentro del lapso de 90 días.

DOH-3474es (04/09)

Appendix E

POWER OF ATTORNEY

* Please note that this form may be subject to change in 2021

POWER OF ATTORNEY
NEW YORK STATUTORY SHORT FORM

(a) CAUTION TO THE PRINCIPAL: Your Power of Attorney is an important document. As the "principal," you give the person whom you choose (your "agent") authority to spend your money and sell or dispose of your property during your lifetime without telling you. You do not lose your authority to act even though you have given your agent similar authority.

When your agent exercises this authority, he or she must act according to any instructions you have provided or, where there are no specific instructions, in your best interest. "Important Information for the Agent" at the end of this document describes your agent's responsibilities.

Your agent can act on your behalf only after signing the Power of Attorney before a notary public.

You can request information from your agent at any time. If you are revoking a prior Power of Attorney, you should provide written notice of the revocation to your prior agent(s) and to any third parties who may have acted upon it, including the financial institutions where your accounts are located.

You can revoke or terminate your Power of Attorney at any time for any reason as long as you are of sound mind. If you are no longer of sound mind, a court can remove an agent for acting improperly.

Your agent cannot make health care decisions for you. You may execute a "Health Care Proxy" to do this.

The law governing Powers of Attorney is contained in the New York General Obligations Law, Article 5, Title 15. This law is available at a law library, or online through the New York State Senate or Assembly websites, www.senate.state.ny.us or www.assembly.state.ny.us.

If there is anything about this document that you do not understand, you should ask a lawyer of your own choosing to explain it to you.

SAMPLE

(b) DESIGNATION OF AGENT(S):

I, _____ _____
(name of principal) *(address of principal)*

hereby appoint:

_____ _____
(name of agent) *(address of agent)*

_____ _____
(name of second agent) (*address of second agent*)

as my agent(s).

If you designate more than one agent above, they must act together unless you initial the statement below.

(____) My agents may act SEPARATELY.

(c) DESIGNATION OF SUCCESSOR AGENT(S): (OPTIONAL)
If any agent designated above is unable or unwilling to serve, I appoint as my successor agent(s):

_____ _____
(*name of successor agent*) (*address of successor agent*)

_____ _____
(*name of second successor agent*), (*address of second successor agent*)

Successor agents designated above must act together unless you initial the statement below.

(____) My successor agents may act SEPARATELY.

You may provide for specific succession rules in this section. Insert specific succession provisions here:

(d) This POWER OF ATTORNEY shall not be affected by my subsequent incapacity unless I have stated otherwise below, under "Modifications".

(e) This POWER OF ATTORNEY DOES NOT REVOKE any Powers of Attorney previously executed by me unless I have stated otherwise below, under "Modifications".

If you do NOT intend to revoke your prior Powers of Attorney, and if you have granted the same authority in this Power of Attorney as you granted to another agent in a prior Power of Attorney, each agent can act separately unless you indicate under "Modifications" that the agents with the same authority are to act together.

(f) GRANT OF AUTHORITY:
To grant your agent some or all of the authority below, either
(1) Initial the bracket at each authority you grant, or
(2) Write or type the letters for each authority you grant on the blank line at (P), and initial the bracket at (P). If you initial (P), you do not need to initial the other lines.

I grant authority to my agent(s) with respect to the following subjects as defined in sections 5-1502A through 5-1502N of the New York General Obligations Law:

(____) (A) real estate transactions;

(____) (B) chattel and goods transactions;

(____) (C) bond, share, and commodity transactions;

(____) (D) banking transactions;

(____) (E) business operating transactions;

(____) (F) insurance transactions;

SAMPLE

(____) (G) estate transactions;

(____) (H) claims and litigation;

(____) (I) personal and family maintenance: If you grant your agent this authority, it will allow the agent to make gifts that you customarily have made to individuals, including the agent, and charitable organizations. The total amount of all such gifts in any one calendar year cannot exceed five hundred dollars;

(____) (J) benefits from governmental programs or civil or military service;

(____) (K) health care billing and payment matters; records, reports, and statements;

(____) (L) retirement benefit transactions;

(____) (M) tax matters;

(____) (N) all other matters;

(____) (O) full and unqualified authority to my agent(s) to delegate any or all of the foregoing powers to any person or persons whom my agent(s) select;

(____) (P) EACH of the matters identified by the following letters: _____.

You need not initial the other lines if you initial line (P).

(g) MODIFICATIONS: (OPTIONAL)

In this section, you may make additional provisions, including language to limit or supplement authority granted to your agent. However, you cannot use this Modifications section to grant your agent authority to make gifts or changes to interests in your property. If you wish to grant your agent such authority, you MUST complete the Statutory Gifts Rider.

(h) CERTAIN GIFT TRANSACTIONS: STATUTORY GIFTS RIDER (OPTIONAL)

In order to authorize your agent to make gifts in excess of an annual total of $500 for all gifts described in (I) of the grant of authority section of this document (under personal and family maintenance), you must initial the statement below and execute a Statutory Gifts Rider at the same time as this instrument. Initialing the statement below by itself does not authorize your agent to make gifts. The preparation of the Statutory Gifts Rider should be supervised by a lawyer.

(____) (SGR) I grant my agent authority to make gifts in accordance with the terms and conditions of the Statutory Gifts Rider that supplements this Statutory Power of Attorney.

(i) DESIGNATION OF MONITOR(S): (OPTIONAL)

If you wish to appoint monitor(s), initial and fill in the section below:

(____) I wish to designate _____, whose address(es) is (are) _____, as monitor(s). Upon the request of the monitor(s), my agent(s) must provide the monitor(s) with a copy of the power of attorney and a record of all transactions done or made on my behalf. Third parties holding records of such transactions shall provide the records to the monitor(s) upon request.

(j) COMPENSATION OF AGENT(S): (OPTIONAL)

Your agent is entitled to be reimbursed from your assets for reasonable expenses incurred on your

SAMPLE

behalf. If you ALSO wish your agent(s) to be compensated from your assets for services rendered on your behalf, initial the statement below. If you wish to define "reasonable compensation", you may do so above, under "Modifications".

(____) My agent(s) shall be entitled to reasonable compensation for services rendered.

(k) ACCEPTANCE BY THIRD PARTIES:

I agree to indemnify the third party for any claims that may arise against the third party because of reliance on this Power of Attorney. I understand that any termination of this Power of Attorney, whether the result of my revocation of the Power of Attorney or otherwise, is not effective as to a third party until the third party has actual notice or knowledge of the termination.

(l) TERMINATION:

This Power of Attorney continues until I revoke it or it is terminated by my death or other event described in section 5-1511 of the General Obligations Law.

Section 5-1511 of the General Obligations Law describes the manner in which you may revoke your Power of Attorney, and the events which terminate the Power of Attorney.

(m) SIGNATURE AND ACKNOWLEDGMENT:

In Witness Whereof I have hereunto signed my name on the ____ day of _____, 20__

PRINCIPAL signs here: ====> _____

STATE OF NEW YORK)
) ss:
COUNTY OF _____)

On the ____ day of _____, 20__, before me, the undersigned, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her capacity, and that by his/her signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument.

_____
Notary Public

(n) IMPORTANT INFORMATION FOR THE AGENT:

When you accept the authority granted under this Power of Attorney, a special legal relationship is created between you and the principal. This relationship imposes on you legal responsibilities that continue until you resign or the Power of Attorney is terminated or revoked. You must:

(1) act according to any instructions from the principal, or, where there are no instructions, in the principal's best interest;
(2) avoid conflicts that would impair your ability to act in the principal's best interest;

(3) keep the principal's property separate and distinct from any assets you own or control, unless otherwise permitted by law;
(4) keep a record or all receipts, payments, and transactions conducted for the principal; and

SAMPLE

(5) disclose your identity as an agent whenever you act for the principal by writing or printing the principal's name and signing your own name as "agent" in either of the following manners: (Principal's Name) by (Your Signature) as Agent, or (your signature) as Agent for (Principal's Name).

You may not use the principal's assets to benefit yourself or anyone else or make gifts to yourself or anyone else unless the principal has specifically granted you that authority in this document, which is either a Statutory Gifts Rider attached to a Statutory Short Form Power of Attorney or a Non-Statutory Power of Attorney. If you have that authority, you must act according to any instructions of the principal or, where there are no such instructions, in the principal's best interest.

You may resign by giving written notice to the principal and to any co-agent, successor agent, monitor if one has been named in this document, or the principal's guardian if one has been appointed. If there is anything about this document or your responsibilities that you do not understand, you should seek legal advice.

Liability of agent: The meaning of the authority given to you is defined in New York's General Obligations Law, Article 5, Title 15. If it is found that you have violated the law or acted outside the authority granted to you in the Power of Attorney, you may be liable under the law for your violation.

(o) AGENT'S SIGNATURE AND ACKNOWLEDGMENT OF APPOINTMENT:

It is not required that the principal and the agent(s) sign at the same time, nor that multiple agents sign at the same time.

I/we, _____, have read the foregoing Power of Attorney. I am/we are the person(s) identified therein as agent(s) for the principal named therein.

I/we acknowledge my/our legal responsibilities.

Agent(s) sign(s) here: ==> _____

==> _____

STATE OF NEW YORK)
) ss:
COUNTY OF _____)

On the _____ day of _____, 20__, before me, the undersigned, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her capacity, and that by his/her signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument.

_____
Notary Public

SAMPLE

(p) SUCCESSOR AGENT'S SIGNATURE AND ACKNOWLEDGMENT OF APPOINTMENT:

It is not required that the principal and the SUCCESSOR agent(s), if any, sign at the same time, nor that multiple SUCCESSOR agents sign at the same time. Furthermore, successor agents can not use this power of attorney unless the agent(s) designated above is/are unable or unwilling to serve.

I/we, _____, have read the foregoing Power of Attorney. I am/we are the person(s) identified therein as SUCCESSOR agent(s) for the principal named therein.

Successor Agent(s) sign(s) here: ==> _____

==> _____

STATE OF NEW YORK)
) ss:
COUNTY OF _____)

On the _____ day of _____, 20___, before me, the undersigned, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her capacity, and that by his/her signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument.

SAMPLE

_____
Notary Public

POWER OF ATTORNEY
NEW YORK STATUTORY GIFTS RIDER
AUTHORIZATION FOR CERTAIN GIFT TRANSACTIONS

CAUTION TO THE PRINCIPAL: **This OPTIONAL rider allows you to authorize your agent to make gifts in excess of an annual total of $500 for all gifts described in (I) of the Grant of Authority section of the statutory short form Power of Attorney (under personal and family maintenance), or certain other gift transactions during your lifetime. You do not have to execute this rider if you only want your agent to make gifts described in (I) of the Grant of Authority section of the statutory short form Power of Attorney and you initialed "(I)" on that section of that form. Granting any of the following authority to your agent gives your agent the authority to take actions which could significantly reduce your property or change how your property is distributed at your death. "Certain gift transactions" are described in section 5-1514 of the General Obligations Law. This Gifts Rider does not require your agent to exercise granted authority, but when he or she exercises this authority, he or she must act according to any instructions you provide, or otherwise in your best interest.**

This Gifts Rider and the Power of Attorney it supplements must be read together as a single instrument.

Before signing this document authorizing your agent to make gifts, you should seek legal advice to ensure that your intentions are clearly and properly expressed.

SAMPLE

(a) GRANT OF LIMITED AUTHORITY TO MAKE GIFTS

Granting gifting authority to your agent gives your agent the authority to take actions which could significantly reduce your property.

If you wish to allow your agent to make gifts to himself or herself, you must separately grant that authority in subdivision (c) below.

To grant your agent the gifting authority provided below, initial the bracket to the left of the authority.

(_____) I grant authority to my agent to make gifts to my spouse, children and more remote descendants, and parents, not to exceed, for each donee, the annual federal gift tax exclusion amount pursuant to the Internal Revenue Code. For gifts to my children and more remote descendants, and parents, the maximum amount of the gift to each donee shall not exceed twice the gift tax exclusion amount, if my spouse agrees to split gift treatment pursuant to the Internal Revenue Code. This authority must be exercised pursuant to my instructions, or otherwise for purposes which the agent reasonably deems to be in my best interest.

(b) MODIFICATIONS:

Use this section if you wish to authorize gifts in amounts smaller than the gift tax exclusion amount, in amounts in excess of the gift tax exclusion amount, gifts to other beneficiaries, or other gift transactions. Granting such authority to your agent gives your agent the authority to take actions which could significantly reduce your property and/or change how your property is

distributed at your death. If you wish to authorize your agent to make gifts to himself or herself, you must separately grant that authority in subdivision (c) below.

(_____) I grant the following authority to my agent to make gifts pursuant to my instructions, or otherwise for purposes which the agent reasonably deems to be in my best interest:

(c) GRANT OF SPECIFIC AUTHORITY FOR AN AGENT TO MAKE GIFTS TO HIMSELF OR HERSELF: (OPTIONAL)

If you wish to authorize your agent to make gifts to himself or herself, you must grant that authority in this section, indicating to which agent(s) the authorization is granted, and any limitations and guidelines.

(_____) I grant specific authority for the following agent(s) to make the following gifts to himself or herself:

This authority must be exercised pursuant to my instructions, or otherwise for purposes which the agent reasonably deems to be in my best interest.

(d) ACCEPTANCE BY THIRD PARTIES:

I agree to indemnify the third party for any claims that may arise against the third party because of reliance on this Statutory Gifts Rider.

(e) SIGNATURE OF PRINCIPAL AND ACKNOWLEDGMENT:

In Witness Whereof I have hereunto signed my name on _____, 20__.

PRINCIPAL signs here: ====> _____

STATE OF NEW YORK)
) ss:
COUNTY OF _____)

On the ____ day of _____, 20__, before me, the undersigned, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in her/his capacity, and that by her/his signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument.

_____
Notary Public

SAMPLE

(f) SIGNATURES OF WITNESSES:

By signing as a witness, I acknowledge that the principal signed the Statutory Gifts Rider in my presence and the presence of the other witness, or that the principal acknowledged to me that the principal's signature was affixed by him or her or at his or her direction. I also acknowledge that the principal has stated that this Statutory Gifts Rider reflects his or her wishes and that he or she has signed it voluntarily. I am not named herein as a permissible recipient of gifts.

_____	_____
Signature of witness 1	Signature of witness 2
_____	_____
Date	Date
_____	_____
Print Name	Print Name
_____	_____
Address	Address
_____	_____
City, State, Zip code	City, State, Zip code

(g) This document prepared by:

SAMPLE

Suggested Modifications to New York Statutory Gifts Rider

Please review these carefully to ensure these modifications are applicable to/desired by the Principal.

Exclusionary Gifting Modifications

(b) to make gifts to my parents, spouse, children and other descendants, not to exceed, for each donee, the annual federal gift tax exclusion amount pursuant to the Internal Revenue Code. The maximum amount of the gift to each donee shall not exceed twice the gift tax exclusion amount, if my spouse agrees to split gift treatment pursuant to the Internal Revenue Code.

(c) my agent(s), _____ *and* _____ , may make gifts to him, her or themselves, as the case may be, not to exceed, for each donee, the annual federal gift tax exclusion amount pursuant to the Internal Revenue Code. The maximum amount of the gift to each donee shall not exceed twice the gift tax exclusion amount, if my spouse agrees to split gift treatment pursuant to the Internal Revenue Code.

Full Gifting Modifications

(b) Modifications

1) to transfer, gift or convey any and all property that I may own as I may do under all circumstances for purposes of gift, estate or tax planning, Medicaid planning or for whatever purposes my agent(s) deems appropriate.

2) to make or change all beneficiary designations, withdrawals, rollovers, transfers, elections and waivers under law regarding all life insurance contracts, annuity contracts, qualified plans, employee benefit plans and individual retirement accounts, whether as plan participant, as beneficiary, IRA owner or as spouse of a participant, including, without limitation, the waiver of qualified joint and survivor annuity and qualified pre-retirement survivor annuity benefits as provided in I.R.C. § 417; to authorize any distribution, transfer or rollover from all qualified plans and IRAs.

3) to create trusts, whether revocable or irrevocable, on my behalf; to fund such trusts on my behalf or to make transfers and additions to any trusts already in existence; to withdraw income or principal on my behalf from any trust; to exercise whatever trust powers or elections which I may exercise; to open, modify or terminate deposit accounts and any other joint accounts, in my name and the name of other joint tenants, bank accounts in trust form and transfer on death accounts, and to designate or change the beneficiary(ies) of such accounts.

(c) *My agent(s),* _____ *and* _____ *, may:*

1) Transfer, gift or convey any and all property that I may own as I may do under all circumstances for purposes of gift, estate or tax planning, Medicaid planning or for whatever purposes my agent(s) deems appropriate. This grant of authority shall include the ability of my agent(s) to transfer, gift or convey any and all property to himself, herself, or themselves, as the case may be.

SAMPLE

2) Make or change all beneficiary designations, withdrawals, rollovers, transfers, elections and waivers under law regarding all life insurance contracts, annuity contracts, qualified plans, employee benefit plans and individual retirement accounts, whether as plan participant, as beneficiary, IRA owner or as spouse of a participant, including, without limitation, the waiver of qualified joint and survivor annuity and qualified pre-retirement survivor annuity benefits as provided in I.R.C § 417; authorize any distribution, transfer or rollover from all qualified plans and IRAs. This grant of authority shall include the ability of my agent(s) to make or change said beneficiary designations, withdrawals, rollovers, transfers, elections and waivers to name himself, herself, or themselves, as the case may be, as the beneficiary(ies) thereof.

3) Create trusts, whether revocable or irrevocable, on my behalf; fund such trusts on my behalf or make transfers and additions to any trusts already in existence; withdraw income or principal on my behalf from any trust; exercise whatever trust powers or elections which I may exercise; open, modify or terminate deposit accounts and any other joint accounts, in my name and the name of other joint tenants, bank accounts in trust form and transfer on death accounts, and designate or change the beneficiary(ies) of such accounts. This grant of authority shall include the ability of my agent(s) to create trusts or accounts naming himself, herself, or themselves, as the case may be, as the beneficiary(ies) or joint tenant(s) of such trusts or accounts.

Other Possible Modifications

(Please review these carefully to ensure these modifications are applicable to/desired by the Principal. Some of the modifications are mutually exclusive.) Modifications may be made under paragraph (b) and/or (c) as indicated below.

Paragraph (b)

1. Any gift of my property may be transferred in cash or in kind, and may pass outright to the recipient or may be transferred to a custodian under the Uniform Transfer to Minors Act, which may be established by my agent.

2. Any gift made of my property may be transferred to a trust for the benefit of the recipient. Such trust may be an existing trust or a trust which can be created by my agent for the benefit of the recipient.

3. In making gifts of my property, my "best interest" shall include gifts which would be likely to cause a reduction in estate tax due or which would carry out a plan for the protection of my assets against the costs of nursing home care in the foreseeable future.

4. My agent shall be authorized to make gifts to charities or individuals so long as such gifts are consistent with a gifting pattern I have established previously. For example, charitable pledges, regular gifts to my church or other charities may be carried out or continued at the levels at which I have previously given.

Paragraph (b and c)

5. My wife/husband shall be entitled to give herself/himself any amount of my property. She/he shall also be entitled to give any amount of my property to any descendant of mine without regard to equality or proportionality.

SAMPLE

6. When a child of mine acts as agent hereunder, the agent/child shall be prohibited from making any gift to himself/herself that exceeds the least amount, which is gifted to a sibling of the agent or to the descendants, collectively, of any deceased sibling.

7. Any agent who is not my spouse or descendant shall not be eligible to receive any gift of my property hereunder.

SAMPLE

Appendix F

How to get Medicaid Despite Having Excess Income

NYLAG New York Legal Assistance Group

HOW TO USE A POOLED INCOME TRUST TO OBTAIN MEDICAID WITHOUT A "EXCESS INCOME" OR SPEND-DOWN (AGE 65+/DISABLED)

The Problem: Medicaid serves people with limited finances, including elderly, blind, and disabled persons. The Medicaid levels are $875 for singles and $1,284 for couples (2020).[1] People whose income exceeds these levels must "spend-down" their income to meet these levels. The amount by which their income exceeds these levels after they have paid for Medicare Part B and any other health insurance premiums is referred to as the "spend-down." Every month, they must first incur medical bills in an amount that equals their "spend-down" to qualify for Medicaid. Some people may be able to meet their "spend-down" by using bills other than their current regular monthly medical bills.[2]

With living costs so high in New York, no one can live at the Medicaid levels. The "spend-down" is a huge burden and makes it impossible for many people to get Medicaid.

> **Why Do I Need Medicaid?** Medicaid provides access to **home care**, which is not paid for by Medicare, and which is very expensive when paid for out of pocket. Also, any Medicaid beneficiary is deemed eligible for **Extra Help**, the Low Income Subsidy for the Medicare Part D drug program. This pays the monthly Part D premium, eliminates the annual deductible and "donut hole," and reduces drug copayments.

The Solution: People of any age who are disabled may enroll in a pooled "Supplemental Needs Trust" sponsored by a non-profit organization. There are now many pooled trusts in New York State. This fact sheet uses one trust—the Center for Disability Rights (CDR) pooled trust—as an example.[3] The Trust is open to any person who is "disabled" as defined by the Social Security laws. When the client joins the Trust, she agrees to deposit with the Trust each month the amount of her "spend-down." Once the Trust documents are signed, and the local Medicaid program approves the Trust enrollment, Medicaid will change the budget so that the client has

[1] Medicaid further grants a disregard of $20/mo. per household of unearned income for disabled, aged and blind applicants. There is also a disregard available for earned income, which is beyond the scope of this fact sheet.

[2] They can use to meet the spend-down:

- old unpaid and unreimbursed medical bills they still owe and paid bills for medical care received within the 3 months before they applied for Medicaid
- over-the-counter or other medical expenses Medicaid and Medicare do not pay for, if a doctor says in writing that they are medically necessary
- the amounts that EPIC or ADAP have paid for their prescription costs, beginning up to three months before they applied for Medicaid, in addition to the co-payments the client pays for these programs

See complete outline on spend-down posted at http://wnlc.com/health/download/70/

[3] There are many non-profit organizations in New York that offer pooled Supplemental Needs Trusts- see http://wnylc.com/health/entry/4/ for an unofficial list.

2.

NO SPEND-DOWN. The client requests the Trust to pay certain bills, such as rent, mortgage, electric, etc. from the money the client sends in each month. This is explained more below.

EXAMPLE

Sally is age 67. Her gross Social Security is $1,875 per month. Her Medicare Part B premium of $144.60 is deducted from her check, so she receives $1,739.50. She also pays for an AARP Medigap policy of $261/mo.

Sally's spend-down calculation is:

Total Income		
	$1875.00	Gross Income
	- 144.60	- Medicare Part B premium
	- 20.00	- Disregard for aged, disabled (standard
	- 261.00	AARP - Medigap premium (Plan F)
	- 425.60	TOTAL DEDUCTIONS
	- 1449.40	Countable net income
	- 875.00	- Medicaid level for ONE (2020)
	$ 574.40	**Spend-down or Excess Income**

Monthly Expenses	
Rent	$850
Con Ed, phone	100 (average)
AARP Medigap	261 (was deducted in Medicaid budget)
Food	280
Transportation	80
Cable	70
Clothing	234
TOTAL	$1875

WHAT'S INSIDE

Explanation of the steps to enroll in a pooled trust, how to figure out how much to deposit into the trust, and how to ask Medicaid to eliminate your spend-down.....**pages 3–10**

"Frequently Asked Questions" explaining what expenses the trust may pay for, how do you leave a pooled trust, and links to more information.....**pages 11–14**

UPDATE ABOUT THE TIMING OF APPLICATION AND JOINING TRUST 3.

A Medicaid application must be decided within 45 days, unless it requires a determination of disability, in which case federal regulations allow 90 days for processing. Approval of a pooled trust for an individual age 65+ requires the local Medicaid agency to determine that they are "disabled." (People under age 65 who are disabled usually receive Social Security Disability benefits so do not need a determination of disability by Medicaid). For those 65+, if the trust is submitted with the application, the agency has 90 days to approve the application with the pooled trust. The problem is that in reality HRA and the other local districts take much longer to approve a pooled trust than the 45-day and 90-day limits in the federal regulations. For that reason, we used to recommend that it would be faster to apply for Medicaid first without the trust, allowing home care to get started, though with a spend-down, then submit the trust after the application was approved.

At least in New York City, there is now an advantage of submitting the pooled trust along with the application. In March 2019, a federal court approved a settlement in a class action called Garcia v. Banks, which requires NYC HRA to comply with the 90-day deadline to approve Medicaid applications submitted with a pooled trust for an applicant age 65+ (which require a finding that the applicant is "disabled."). While 90 days may still seem like a long time, approval of the application along with the trust in 90 days is a big improvement over past delays. However, the court order only requires HRA to approve the application with the SNT within the 90-day limit if the trust is submitted with the Medicaid application, not separately. If you have submitted a trust with a Medicaid application in NYC for someone age 65+, and a decision was not made in 90 days, contact Garcia class counsel, Nina Keilin ninakeilin@aol.com or Aytan Bellin Aytan.Bellin@bellinlaw.com. In the application, the applicant may still request HRA/DSS to approve the application initially with a spend-down in order to expedite it, and to approve the pooled trust and re-budget the case later within 90 days.

Outside NYC, the 90 day time limit still applies to an application submitted with a trust for someone age 65+, but there is not a court order enforcing that time limit. The best strategy may vary in each county.

STEPS FOR ENROLLING IN A POOLED TRUST

4.

There are four steps to enrolling into a pooled trust, each of which is explained below with forms available here: http://www.wnylc.com/health/entry/44/

The four steps are:

1. Enroll in the Pooled Supplemental Needs Trust
2. Decide How Much to Deposit into the Trust
3. Apply for Medicaid Home Care with Trust Documents and Proof of Disability
4. Follow-Up and Ensure Medicaid Budgeting Is Done Correctly

✓ STEP 1 - Enroll in the Pooled Supplemental Needs Trust

The first step is to enroll in the pooled SNT. Most pooled SNTs have a list of documents on their website, including FAQs and Procedures which you should read before enrolling. There are many Pooled SNTs in New York, available at http://www.wnylc.com/health/entry/4/.

Using the Center for Disability Rights (CDR) SNT as an example, here is what you need to send CDR to enroll. All forms can be downloaded – see link in CDR entry on the list of trusts found at http://www.wnylc.com/health/entry/4/. All trusts have different enrollment fees and forms.

- Beneficiary Profile & Joinder Agreement - Filled out and signed before a notary public.
- Disbursement/Withdrawal Form - For every expense that you want CDR to pay for you, you need to submit one of these forms and attach proof that the amount is due (e.g. a copy of your lease, monthly utility bill, credit card statement). Carefully read the SNT's rules to make sure they will pay the type of expense. Remember the expense has to be yours and not anyone else's or a gift for anyone else. Also, the SNT will never pay you – the Medicaid recipient -- directly.
- ACH Request Form - If you want CDR to make automatic withdrawals from your bank account each month in the amount of your monthly SNT contribution. You can specify the day of the month that the withdrawal is made.
- FEE - Enrollment funds (check or money order) - Payable to CDR (minimum initial deposit is $240 but see below for advice about how much to send for your full monthly contribution). Every trust has different fees. For example, see the NYSARC Community Trust II Fee Schedule - https://www.nysarctrustservices.org/download_file/6/144/ and see other trusts at http://www.wnylc.com/health/entry/4/.

CDR and the other trust organizations will take about 2 weeks to process your application, and if you are enrolled in their SNT, they will send you an Acceptance Letter. Keep that handy because you will need it in Step Three.

✓ **STEP 2 - Decide How Much to Deposit into the Trust**

Here are some tips for deciding how much to put into the trust each month. For help determining the appropriate amount to contribute each month to eliminate your spend-down, obtain the Medicare Savings Program, and ensure that all SNT fees and your bills are paid, use this Excel worksheet at http://www.wnylc.com/health/download/316/.

The Bare Minimum – Actual Spend-down amount. At a minimum, deposit your actual spend-down. For example, if Sally (example on page 2 above) deposits $599.50 each month into the Trust, once Medicaid approves it, she will have NO spend-down. With this option, CDR keeps $20 as a monthly fee, and $579.00 is available to pay her bills.

Strategy Tip #1: Enough to pay full rent: How much should she put in the Trust each month if she wants the Trust to pay her rent? If she puts her exact spend-down of $599.50 into the Trust, so that $579.50 is left to pay her bills after the Trust fee, she could have the trust pay $579.50 of the rent and she would pay the balance to the landlord. Alternately, she can deposit $870 that would include the $20 fee and the $850 rent. Some trusts, such as NYSARC have a fee scale with higher fees for higher monthly deposits. The convenience of having the trust pay the whole rent may be worth it.

Strategy Tip #2: Extra benefit of the Trust - Medicare Savings Program (MSP): By reducing one's "countable" income, one also becomes eligible for one of the Medicare Savings Programs. These programs pay the Medicare Part B premium—$144.60 in 2020—a savings that more than offsets the monthly Trust fee. For the income limits and more info see: http://tinyurl.com/W393P and http://wnylc.com/health/entry/99. Once Medicaid starts paying her Part B premium through the MSP, her Social Security check will increase by $144.60. As a result, her spend-down will also increase by $144.60. If Sally wants to be in MSP, and also have no spend-down, she should increase her monthly trust deposit by $144.60. For help determining the appropriate amount to contribute each month to eliminate your spend-down, obtain the Medicare Savings Program, and ensure that all SNT fees and your bills are paid, you can use this Excel worksheet (http://www.wnylc.com/health/download/316/).

. ** MSP TIP: If you were contributing the extra $144.60 to the SNT, you will be retroactively enrolled in MSP, and you will receive a reimbursement for the Part B premiums you paid while contributing to the SNT. For this to work, you must continue making your deposit in the SNT every month.

** APPLICATION TIP WITH MSP: On the Medicaid application, write across the top of the first page that the client is applying for both Medicaid AND the Medicare Savings Program. The Medicaid office is required to screen the client for MSP anyway, but it helps to remind them. See GIS 05/MA033, at http://tinyurl.com/L7AUSK .

Strategy Tip #3: WARNING - Deposit only what you can routinely spend every month - Do not let the trust deposit accumulate! If you do not spend the money deposited each month into the Trust, and it accumulates, then you may be denied Medicaid to pay for nursing home care if you need it in the next five years. This is because of the Deficit Reduction Act enacted Feb. 8, 2006. Transfers of assets made by someone age 65 or over after that date can cause a delay (transfer penalty) in qualifying for Medicaid to pay for nursing home care for five years. This delay for nursing home eligibility can also be triggered by transfers of income into a Trust by someone age 65+ if the income is not spent. Fortunately, the New York State Department of Health has said that placing income into a pooled Trust will not result in a transfer penalty for Medicaid coverage of nursing home care, as long as the balance of the pooled Trust account does not accumulate. NYS Dept. of Health GIS 08 MA/020, Transfers to Pooled Trusts by Disabled Individuals Age 65 and Over (July 24, 2008), available at https://www.health.ny.gov/health_care/medicaid/publications/docs/gis/08ma020.pdf. If the individual needs Medicaid coverage of nursing home care in the future, the amount of money remaining in the trust account that has not been spent on rent and other expenses will be deemed a transfer of assets and a penalty imposed. For more information on these rules, see http://wnylc.com/health/entry/38/.

Strategy Tip #4: Married couples - If both spouses need Medicaid, it may be possible for only one to establish a Trust account, depending on their respective incomes. This can spare the couple administrative fees and administrative hassle. Their combined income remaining after taking all deductions, and after the deposit into the Trust, must still be the Medicaid couple income limit ($1284/mo. in 2020).

MARRIED COUPLE EXAMPLE:

Sally has the same income and insurance as in the example above, but is married to John whose gross income is $900. John and Sally also have the same AARP Medigap policy. Their budget would be as follows:

$1875.00	Gross Income - Sally
900.00	Gross Income - John
2775.00	TOTAL GROSS INCOME
- 289.20	Medicare Part B premium x 2
- 20.00	Disregard for aged, disabled ($20/1 or 2)
- 313.00	AARP Medigap premium (Plan A) (156.50 x 2)
- 622.20	TOTAL DEDUCTIONS
2152.80	Countable net income
2152.80	Countable net income
- 1284.00	Medicaid level for TWO (2020)
868.80	Spend-down as a couple
289.20	Extra for Medicare Savings Prog. (Part B x 2)
$1158.00	Total to deposit if want MSP

If they are applying as a couple, assuming they are both either disabled or 65+, it makes more sense for Sally to establish a trust, since John's income isn't high enough to deposit $1158.00, which is the full spend-down plus the extra $289.20 if they want to enroll in an MSP and still have no spend-down. Since John only has $900 in income, it may make more sense to keep his entire income, and have Sally enroll in the Trust and deposit $1158.00 into the Trust. But note: if Sally was not disabled, then only John could enroll in the Trust.[4] And in some cases, both spouses will need to join the Trust if both have higher incomes.

[4] Let's say John enrolled in the Trust because Sally was not disabled. But let's say his income was much lower - only $500 and hers was $500 higher than in the example. One fair hearing decision held that he may deposit HER income into HIS Trust to reduce his or their spend-down. See In the Matter of J.T., Fair Hearing No. 4576742M (Nov. 16, 2006), available from Fair Hearing Database at http://onlineresources.wnylc.net

Strategy Tip #5: If you don't have Medicare, don't reduce spend-down to ZERO-Keep a nominal spend-down - Even a few dollars. Why? For people who do not have Medicare, it may be advantageous to retain a minimal spend-down to avoid being required to enroll in a Medicaid Managed Care Plan. Currently, having a spend-down makes one exempt from the requirement to enroll in a Managed Care Plan. See at http://wnylc.com/health/entry/166/. (If the client has Medicare and needs long term care, she will be required to enroll in a Medicaid Managed Long Term Care plan even if she has a spend-down.)

✓ STEP 3 - Apply for Medicaid Home Care with Trust Documents and Proof of Disability

The third step is to apply for Medicaid. See the note on page 3 above about Timing of applying for Medicaid and submitting trust. Whether to submit the trust with the application may vary depending on whether you are in NYC or elsewhere. Even if you submit the trust with your application, you can request the Medicaid agency to first approve you with a spend-down, and then later process the pooled trust.

When you are approved for Medicaid with a spend-down, if you begin receiving home care from a Managed Long Term Care (MLTC) plan or other home care agency, you are expected to pay your spend-down to the plan or agency every month. You will probably be unable to do this because you are sending the money to the SNT. Explain to the plan or agency that your spend-down will eventually be retroactively reduced to zero and that they will then be able to back-bill Medicaid for the spend-down amount. Some plans will ask for proof that you have submitted your SNT enrollment to Medicaid for approval.

Applicants for Medicaid who want to enroll in MLTC must make it clear at the time of application that they wish to ultimately enroll in an MLTC plan.

1. Proof that you are enrolled in a SNT - You need to send:

- **Master Trust Agreement**- available as a printable PDF on the SNT's website
- **Beneficiary Profile Sheet and Joinder Agreement**, signed by both you and the trustee (CDR for example) - The version sent to you with your Acceptance Letter will have the trustee's signature
- **Acceptance Letter**
- **Verification of Deposits** - If you are sending this paperwork more than a month after you were accepted into the SNT, you need to send proof that you have been making monthly deposits. You can call the SNT to ask for a statement.

2. Proof that you are disabled- DOWNLOAD forms listed below at http://www.wnylc.com/health/entry/134 /

- If you have been approved for either SSDI or SSI benefits on the basis of a disability, then all you have to send to prove that you are disabled is a copy of your SSA Award Letter or SSA Disability Determination (that you got when you were first approved for benefits). Otherwise, you need to send the documents below and ask the DSS for a disability determination (http://www.wnylc.com/health/entry/134/)

- DSS-486T - Medical Report for Determination of Disability (Rev. 6/2012) This form needs to be filled out by your doctor(s). In January 2013, HRA published a Medicaid Alert stating that 12 months of medical records must be included with every 486T form. http://www.wnylc.com/health/download/402/. So if your primary care physician filled out a 486T, you need to send 12 months of records from their office. If any of your specialists filled out 486Ts then you need to send 12 months of records from their offices as well. If you are able to get records from any hospitalizations or nursing home stays in the past 12 months, send those too. You want to ensure that the medical information you send gives Medicaid a clear picture of your medical and psychological conditions for them to base their disability determination on. So if your primary disability is treated by a specialist(s), be sure to get the 486T and medical records from that doctor(s).

    - NOTE: The 486T form revised in June 2012 shortens the form from a 25-page form to a one page form, which is less intimidating to doctors. The old form consisted of numerous attachments that elicited information about the different body systems, such as a musculoskeletal or cardiac impairments. Those attachments, while burdensome, were helpful to show the criteria for "meeting the listings" to be found disabled (Step Three in the sequential evaluation process described in this article). http://wnylc.com/health/entry/134/. While no longer required, you might find some of these attachments helpful as a guide for your physician to provide information about particular conditions. Click here for the old 486T . http://www.wnylc.com/health/download/60/.

- DSS-1151 - Disability Questionnaire (Rev. 6/2012 to replace Disability Interview Form) http://www.health.ny.gov/health_care/medicaid/publications/docs/gis/12ma027att2.pdf
  This form can be filled out by you, a social worker or family member.

- LDSS-1151.1 (6/2012) Disability Questionnaire Continuation Sheet - If you need more space than the lines on the DSS-1151 to list your medical providers or hospitalizations, you can use this form.

- OCA Official Form 960 - NY State HIPAA
  Per these Medicaid Alerts, http://www.wnylc.com/health/download/599/ and http://www.wnylc.com/health/download/402/, you should submit **four** original copies of this form, signed and dated by the applicant. On three copies, leave the provider information blank. The **fourth** copy should be submitted if you want someone else (e.g., social worker, family member or attorney) to be able to talk with Medicaid about your case, and should name that individual in the two places indicated on the form.

- MAP-751e: Authorization to Release Medical Information
  Per this Medicaid alert, http://www.wnylc.com/health/file/684/?f=1, this form is now required for all disability determinations. http://www.wnylc.com/health/file/685/?f=1

3. **Cover Letter**

- Enclose a cover letter with this great packet of information, to explain what you are asking the DSS to do- budget your Medicaid case with no spend-down - and why- because you have a SNT and are disabled. You can use this sample cover letter (http://www.wnylc.com/health/download/64) as a starting point. You should customize it to apply to your specific medical and psychological conditions and the information in the 486 and 1151 forms.

  - Use the NYS Medicaid Disability Manual (http://www.health.ny.gov/health_care/medicaid/reference/mdm/) as a guide for your specific disability(ies), which explains the "sequential evaluation process" for determining disability, has the Listing of Impairments, and other information.

- You should also ask to be enrolled in the **Medicare Savings Program (MSP)**, to have your Medicare Part B premium paid by Medicaid. Just as using the SNT has brought your income under the limit for Medicaid, if you have been contributing $144.60 more to the SNT than your Medicaid spend-down, it has also brought your income under the limit for MSP. Click here for more information about this program - http://www.wnylc.com/health/entry/99/.

✓ STEP 3 - Apply for Medicaid Home Care with Trust Documents and Proof of Disability

The last step on this journey is to make sure that the Medicaid case is re-budgeted properly. Once you have submitted the SNT and disability documentation to your DSS, they will typically take many months to process the information. You should eventually get a written notice stating that your Medicaid case has been re-budgeted with no spend-down (and telling you that you are enrolled in MSP if you applied for it). Make sure that the **effective date** of this notice is correct - it should be the

month that you first began making a contribution of your full spend down amount (+$144.60 if you wanted MSP) in the SNT. If it is not correct, you may have to request a Fair Hearing to appeal the notice for the date to be corrected (click here to request a hearing - http://otda.ny.gov/hearings/).

As you can see, this is one of the most complicated things you can do involving Medicaid. Many people find that it is worth hiring a private elder attorney (www.naela.org) or geriatric care manager (https://www.aginglifecare.org/) to help with this process. Some free legal services (http://www.lawhelpny.org/) may be available to help, also. For more in-depth information on SNTs, including how a SNT affects eligibility for other public benefits, see our Training Outline for Advocates (http://www.wnylc.com/health/download/9/).

FAQ - see next pages

FREQUENTLY ASKED QUESTIONS

Q: What happens if the spend-down changes once the client has joined the Trust? For example, almost every year, the amount of Social Security increases for most retirees, increasing their spend-down.

A: The client must increase the amount placed into the trust each month. Also, some pooled trusts require a sort of "security deposit" – the equivalent of one month's spend-down to be on deposit at all times. If Social Security or other income goes up, the client may have to increase this deposit as well.

Q: What bills may the Trust pay?

A: WARNING: These rules are for people using a pooled trust solely for Medicaid only, not people who have SSI. If you have SSI and want to use a trust for a lawsuit settlement or other lump sum, the rules are different.

The Trust may pay the client's rent, mortgage, maintenance, utility bills, credit card bills, as long as it makes the payments directly to the landlord or other third party. Such in-kind payments are not considered "income" for Medicaid purposes, regardless of what the payments are for.[5] *The Trust may never give the client money directly* - not even to reimburse the client!

Rent or mortgage payments are the ideal expense for the trust to pay, since these expenses are consistent and most trusts will set up an automatic monthly payment. Some trusts will not put the client on automatic payment of rent or mortgage until the client has been enrolled and paid in the client's spend-down for 3 months. So during the first 3 months the client must make individual disbursement requests for the client's rent or mortgage. After that, ask for automatic payment.

Trusts vary on whether ***utility and other bills*** must be sent each month to the trust for payment, or whether bills on a budget plan with fixed monthly payments ("level billing") may be automatically paid by the trust, like rent.

Though the trust may pay bills only for the benefit of the Trust beneficiary (the client), and NOT for the client's family members or friends, ***payments that incidentally benefit a third party*** may be permissible, such as rent where the client's spouse benefits from the payment. The client needs the trust's permission to pay expenses that benefit a third party, such as paying the expenses for a travel companion of the beneficiary, or travel expenses for a close family member to visit the beneficiary.

Some trusts permit reimbursement to a family member or other individual who paid for a client's expense, such as paying rent or buying clothing, if receipts are submitted.

[5] 18 NYCRR § 360-4.3(e)

However, they must contact the trust to get approval BEFORE making the expenditure to assure reimbursement. The client herself can never be reimbursed.

Some trusts will pay *credit card bills*, provided that the bill is in the client's name, and that there are no past due charges being carried forward. The actual monthly bill must be submitted for the Trust to verify that no cash withdrawals were made. The Trust has the right to inquire whether the expenses were for the benefit of the beneficiary and not for anyone else.

Trusts may not honor disbursement requests for gifts, nor can charitable donations be made from the Trust.

Funds in a trust may pay for a pre-paid funeral agreement while the client is alive. Client may enter an installment plan for a funeral agreement with a funeral home and submit monthly installment bills to the trust to pay. NO POOLED TRUST may pay for funeral expenses after the client dies.

Q: How does the client/beneficiary leave the Trust?

A: The client leaves the Trust when she dies. Money left in the Trust when the client dies stays in the Trust for the benefit of other disabled persons. It may NOT be inherited by the client's family or heirs. Also, after the client's death, the Trust is very limited in what expenses it may pay for the client. The Trust may NOT pay funeral costs after the client's death. The Trust may NOT pay debts owed to third parties, such as paying off a mortgage, credit card debts, etc. The Trust also may NOT pay taxes due upon death, nor fees for administration of the estate. However, the Trust MAY pay the client's current expenses at the time of her death, such as the rent and current bills.

The client leaves when she is admitted to a nursing home. The type of Medicaid budget used in the nursing home does not allow the client to deposit income into a Trust to eliminate the spend-down. Once the client enters a nursing home the client stops making further deposits. The client can still submit expenses requests to the trust to use up any remaining funds.

The client may leave any time by stopping making any further monthly deposits. But if the client does that, the client's spend-down will go up. The spend-down is reduced only as long as the client makes monthly deposits. At annual recertifications, Medicaid will request proof that these deposits are being made.

The trust must be notified in writing of any change in participation of the Trust in order to free up the remaining one month security deposit, if any.

Q: Who can I contact if I have trouble with this process?

A: TROUBLESHOOTING - Each local Medicaid office may have contact people to troubleshoot SNT problems.

In NYC - Here are suggested contacts within HRA. CAUTION: The time limit to request a fair hearing can run out, even if you are trying to informally advocate. Keep your eye on the deadlines!

- **HOME CARE CASES** – When a client has or is seeking MLTC, CHHA or CASA home care, the Medicaid application and SNT documents should be sent to- HRA HCSP Central Medicaid Unit, 785 Atlantic Avenue, 7th Floor, Brooklyn, NY 11238
    - Contact person- Yvette Poole-Brooks poolebrooksy@hra.nyc.gov Phone (929) 221-2493 Fax (718) 636-7848
- **NON-HOME CARE CASES** – The Medicaid application and SNT documents can be turned in at "regular" Medicaid offices where they will then be sent internally to the Spend-Down Unit
    - Contact Person- Eileen Fraser-Smith fraser-smithe@hra.nyc.gov Phone (929) 221-0868/69 Fax (718) 636-7847
    - Eligibility Information Services- Phone (929) 221-0865/66/67/68

ONLINE LINKS - Visit NY Health Access at http://nyhealthaccess.org.

http://wnylc.com/health/14/ - General info on supplemental needs trusts

http://www.wnylc.com/health/download/9/ - training outline on SNTs posted (updated Jan 2019) explaining Supplemental Needs Trusts (both individual and pooled). The Appendix explains how SNTs affect eligibility for many different public benefits.

http://www.wnylc.com/health/entry/134/ -Proof of Disability forms

http://www.wnylc.com/health/entry/4/ - Contact List of pooled trusts in NYS

Webinars – 2013 webinar by David Silva, former Asst. Director EFLRP explaining pooled trusts https://www.youtube.com/watch?v=oRR7VM4HdJ4

- 2019 webinars on SNTs http://www.wnylc.com/health/news/84/

New York Legal Assistance Group (NYLAG), Evelyn Frank Legal Resources Program
For intake please call or email: 212-613-7310 or eflrp@nylag.org
Mon & Wed 10 AM – 2 PM

Appendix G

Managed Long-Term Care (MLTC) Plans Serving New York Statete Having Excess Income

MANAGED LONG-TERM CARE (MLTC) PLANS SERVING NEW YORK STATE

Name	Counties Serviced	Mailing Address/Phone
Aetna Better Health	Kings, New York (Manhattan), Queens, Nassau, Suffolk	55 West 125th St., Suite 1300 New York, NY 10027 (855) 456-9126
AgeWell New York	Bronx, Kings, New York, Queens, Nassau, Suffolk, Westchester	1991 Marcus Ave., Suite M201 Lake Success, NY 11042
Empire BlueCross BlueShield - Health Plus MLTC (formerly HealthPlus)	New York City (All boroughs)	9 Pine St., 14th Fl New York, NY 1005 (800) 950-7679
Empire BlueCross BlueShield - Health Plus MAP (Formerly HealthPlus	New York City (All boroughs)	9 Pine St., 14th Fl New York, NY 1005 (866) 805-4589
ArchCare Community Life	Bronx, Kings, New York, Queens, Richmond, Putnam, Westchester	33 Irvington Place, 11th FL New York, NY 10003 (855) 467-9351
ArchCare Senior Life	Bronx, New York, Richmond, Westchester	1432 Fifth Ave New York, NY 10035 (866) 263-9083
Catholic Health-LIFE	Erie	55 Melroy Ave Lackawanna, NY 14218 (855) 671-3341
CenterLight Healthcare Select PACE	NYC (All boroughs), Nassau, Suffolk, Westchester	1250 Waters Place Tower 1, Suite 602 Bronx, NY 10461 (877) 226-8500
Centers For Healthy Living	NYC (All boroughs), Erie, Niagara, Nassau, Suffolk, Rockland, Westchester	75 Vanderbilt Ave 7th Floor Staten Island, NY 10304 (855) 270-1600
Complete Senior Care	Niagara	1302 Main St Niagara Falls, NY 14301 (888) 303-4333
Eddy Senior Care	Parts of Albany and Schenectady counties	504 State St Schenectady, NY 12305 (518) 382-3290

MANAGED LONG-TERM CARE (MLTC) PLANS SERVING NEW YORK STATE

Name	Counties Serviced	Mailing Address/Phone
HomeFirst, a product of Elderplan, Inc.	NYC (All boroughs) Dutchess, Nassau, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester	6323 Seventh Ave Brooklyn, NY 11220 (866) 353-4681
Elderwood Health Plan	Erie, Genesee, Monroe, Niagara, Orleans, Wyoming	500 Seneca Street Buffalo, NY 14204
Evercare Choice	Dutchess, Orange, Rockland	31 Cerone Place Newburgh, NY 12550 (855) 299-6492
Extended MLTC, LLC	NYC (All boroughs), Suffolk, Nassau	360 West 31st St., Suite 304 New York, NY 10001 (855) 299-6492
Fallon Health Weinberg MLTC	Erie and Niagara	461 John James Audubon Pkwy Amherst, NY 14228 (866) 882-8185
Fallon Health Weinberg PACE	Erie	461 John James Audubon Pkwy Amherst, NY 14228 (716) 810-1895
Fidelis Care at Home	NYC (All boroughs), all upstate counties	95-25 Queens Blvd Rego Park, NY 11374 (800) 688-7422 (partial)
Fidelis Medicaid Advantage Plus	NYC (All boroughs), Albany, Montgomery, Rensselaer, Schenectady	95-25 Queens Blvd Rego Park, NY 11374 (877) 533-2404 (MAP)
Hamaspik Choice, Inc.	Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster	58 Rt. 59 Suite 1 Monsey, NY 10952 (855) 552-4642
Healthfirst CompleteCare	NYC (All boroughs), Nassau, Westchester	100 Church St., 18th Fl New York, NY 10007 (888) 260-1010
iCircle Care	Broome, Cayuga, Chemung, Chenango, Cortland, Genesee, Livingston, Madison, Monroe, Onondaga, Ontario, Orleans, Oswego, Otdsego, Schuler, Seneca, Steuben, Tioga, Wayne, Tompkins, Wyoming, Yates	860 Hard Rd Webster, NY 14580 (844) 424-7253

MANAGED LONG-TERM CARE (MLTC) PLANS SERVING NEW YORK STATE

Name	Counties Serviced	Mailing Address/Phone
Independent Living for Seniors d/b/a ElderONE	Monroe, Ontario, Wayne	2066 Hudson Ave Rochester, NY 14617 (585) 922-2800
Integra MLTC, Inc.	NYC (All boroughs), Nassau, Suffolk, Westchester	1981 Marcus Ave, Suite 100 Lake Success, NY 11042 (855) 800-4683
Kalos Health	Chautauqua, Erie, Genesee, Monroe, Niagara, Orleans	2424 Niagara Falls Blvd. Suite 400 Niagara Falls, NY 14304 (800) 894-2464
MetroPlus MLTC	Bronx, Kings, New York, Queens	160 Water St New York, NY 10038 (855) 355-6582
Montefiore Diamond Care MLTC	Bronx and Westchester	200 Corporate Blvd. South Yonkers, New York 10701 (855) 556-6683
Nascentia Health	Most upstate counties	1050 W. Genesee St Syracuse, NY 13204 (315) 477-9500
PACE CNY	Onondaga	100 Malta Ln Nrth Syracuse, NY 13212 (888) 728-7223
Partners Health Plan	NYC (All boroughs), Nassau, Suffolk, Rockland, Westchester	655 Third Ave New York, NY 10017
Prime Health Choice LLC	Albany, Dutchess, Orange, Putnam, Rockland, Warren, Washington	3125 Emmons Ave Brooklyn, NY 11235 (855) 777-4630
RiverSpring at Home	NYC (All boroughs), Nassau, Suffolk, Westchester	94 West 225th St, 2nd Fl Bronx, NY 10463 (800) 370-3600
Senior Health Partners A Healthfirst Company	NYC (All boroughs), Nassau, Westchester	100 Church St, 18th Fl New York, NY 10007 (866) 585-9280
Senior Network Health, LLC	Herkimer & Oneida	1650 Champlin Ave Utica, NY 13502 (315) 624-4545

MANAGED LONG-TERM CARE (MLTC) PLANS SERVING NEW YORK STATE

Name	Counties Serviced	Mailing Address/Phone
Senior Whole Health of New York MLTC	Bronx, Kings, New York, Queens	111 Broadway, Suite 1505 New York, NY 10006 (877) 353-0185
Senior Whole Health of New York MAP	Bronx, Kings, New York, Queens, Nassau, Westchester	111 Broadway, Suite 1505 New York, NY 10006 (877) 353-0185
Total Senior Care, Inc,	Allegany, Cattaraugus, Chautauqua	519 North Union St Olean, NY 14760 (716) 379-8474
VillageCareMAX	Bronx, Kings, New York, Queens	112 Charles St New York, NY 10005 (800) 469-6292
VillageCareMAX Medicare Total Advantage	Bronx, Kings, New York, Queens	112 Charles St New York, NY 10005 (800) 469-6292
VNSNY CHOICE Managed Long Term Care	NYC (All boroughs), Albany, Columbia, Delaware, Dutchess, Erie, Fulton, Greene, Herkimer, Madison, Monroe, Montgomery, Nassau, Oneida, Onondaga, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington, Westchester	1250 Broadway, 11th Fl New York, NY 10001 (866) 783-14444
VNSNY CHOICE Total	NYC (All boroughs), Nassau, Suffolk, Westchester	1250 Broadway, 11th Fl New York, NY 10001 (866) 783-14444

Appendix H

Documents Required for Medicaid Application

_____**A. Proof of Identity and Family Relationship – Required for Applicant and Spouse**

_____ Union Card
_____ Social Security Card
_____ Medicare Card
_____ One of the following:
Birth Certificate or Census Records or Baptismal Certificate or Certificate of Naturalization or passport or visa or driver license or non-driver identification card
_____ Military discharge papers
_____ Marriage Certificate or divorce/separation papers
_____ Death Certificate of spouse
_____ Private health insurance card and monthly premium bill
_____ Medicare C and/or D cards and monthly premium bills (if applicable)
_____ Other

_____**B. Residency and Living Arrangement – Required for Applicant and Spouse**

_____ Rent receipt and/or Lease
_____ Most current utility or telephone bill
_____ Deed to residence or co-op share certificates
_____ Other

_____**C. Income – Required for Applicant and Spouse**

_____ Pension or pay stubs
_____ IRA monthly required minimum distribution payments
_____ Support payments – divorce or separation papers
_____ Award Letter for the following benefits:
( ) Social Security (call 1-800-772-1213) for Income Beneficiaries
( ) Military or Veterans Pension

( ) Pension
( ) Railroad Retirement
( ) Insurance endowment
( ) Annuity
( ) New York State Disability
( ) Worker's Compensation

_____ Business records, if self-employed

_____ Past five (5) years of income tax returns, with 1099 Forms (as available)
(Only the most current return is needed for a home care application)

_____ Other: _____

_____**D. Resources – Required for Accounts/Stocks/Bonds/Policies bearing name of Applicant and Spouse**

_____ All bank account statements (with all checks written), IRA account statements, mutual fund statements and investment account statements for the past 60 months (if nursing home application) or the past 3 months (if home care application), including closed accounts*

_____ All passbook bank accounts for the past 60 months (if nursinghome application) or the past 3 months (if home care application), including closed accounts

_____ All checking account statement for the past 60 months (if nursing home application) or the past 3 months (if home care application), including closed accounts with all checks (front and back) in the amount of $2,000 and over*.

_____ Life insurance policies and current cash value

_____ Stock and Bond Certificates

_____ Real estate deeds or co-op shares

_____ Closing papers on property sales

_____ Information about any pending lawsuits

_____ Other: _____

All financial documentation must be accompanied by an explanation for deposits and withdrawals over $2,000. For example, if an account is closed, you must provide the bank name and account number that the funds were transferred to, proof of receipt by that account, and a closed account letter on bank letterhead.

Appendix I

Access New York Health Care
Medicaid Application
(with NYC and non-NYC supplements)

Health Insurance APPLICATION

access NY health care

for Children, Adults and Families

Medicaid

Child Health Plus

family health plus

INSTRUCTIONS

CONFIDENTIALITY STATEMENT All of the information you provide on this application will remain confidential. The only people who will see this information are the Facilitated Enrollers and the State or local agencies and health plans who need to know this information in order to determine if you (the applicant) and your household members are eligible. The person helping you with this application cannot discuss the information with anyone, except a supervisor or the State or local agencies or health plans which need this information.

PURPOSE OF THIS APPLICATION Complete this application if you want health insurance to cover medical expenses. This application can be used to apply for Medicaid, Family Health Plus, Child Health Plus, the Family Planning Benefit Program, or for assistance paying your health insurance premiums. You can apply for yourself and/or immediate family members living with you.

IF YOU NEED HELP COMPLETING THIS APPLICATION DUE TO A DISABILITY, CALL YOUR LOCAL DEPARTMENT OF SOCIAL SERVICES. THEY WILL MAKE EVERY EFFORT TO PROVIDE REASONABLE ACCOMMODATIONS TO ADDRESS YOUR NEEDS.

PLEASE READ the entire application booklet before you begin to fill out the application. If you are applying ONLY for children or if you are a pregnant woman applying alone, you must complete only **Sections A through G and Sections I and J.** Other applicants must complete all sections.

If you are 65 years old or older, certified blind, certified disabled, or institutionalized and applying for coverage of nursing home care, you must **also complete Supplement A.** The supplement includes questions about your resources, such as money in the bank or property you own.

Whenever you see the words **SEND PROOF** on the application refer to the "Documentation Needed When You Apply for Health Insurance" section for a listing of acceptable supporting documents.

HOW TO GET HELP When applying for public health insurance, you **DO NOT** need to visit your local department of social services or a Facilitated Enroller for an interview, but you **MAY** come in or contact a Facilitated Enroller for help filling out this application. **You can get a list of Facilitated Enrollers where you got this application, or by calling 1-800-698-4543. ALL HELP IS FREE.**
(1-877-898-5849 TTY line for the hearing impaired)

SECTION A Applicant's Information

We need to be able to contact the people applying for health insurance. The home address is where the people applying for health insurance live. The mailing address, if different, is where you want us to send health insurance cards and notices about your case. You can also tell us if you want someone else to get information about your case and/or to be able to discuss your case.

SECTION B Household Information

Please include information for everyone who lives with you even if they are not applying for health insurance. It is important that you list everyone who lives with you so that we can make a correct eligibility decision. Include maiden name (legal name before marriage), if this applies to the person. Also include City, State and Country of birth. If a person was born outside of the United States, just write the country of birth. We also need, for each person applying, his/her mother's full maiden name (first and last name). This information may be used to obtain proof of the applicant's birth date under certain circumstances.

- **Is this person pregnant?** If so, when is her baby due to be born? This information helps us determine the size of your family. A pregnant woman counts as two people.
- **Relationship to the person on Line 1.** Explain how each person is related to the person listed on Line 1 (for example, spouse, child, step-child, brother, sister, niece, nephew, etc.)
- **Public Health Coverage.** If you or anyone who lives with you is already enrolled or was previously enrolled in Medicaid, Family Health Plus, Child Health Plus, the Family Planning Benefit Program, or any other form of public assistance such as Food Stamps, we need to know. Also, tell us the identification number on the New York State Benefit Identification Card or plan identification card for Child Health Plus.
- **Social Security Number.** A Social Security Number should be provided for all persons applying, if the person has one. If the person does not have a Social Security Number, leave this box blank.
- **Citizenship and Immigration Status.** This information is needed only for those people applying for health insurance. Pregnant women do not have to complete this question. To be eligible for health insurance, other persons age 19 and over must be U.S. citizens or be in an eligible immigration category. We need to see either original documentation of U.S. citizenship and identity, or certified copies of these documents. Please contact your local department of social services or call 1-800-698-4543 to find out where you can bring these documents. Please note that if you are on Medicare, or receiving Social Security Disability but are not yet eligible for Medicare, it is not necessary to document citizenship or identity.

  Effective July 1, 2010, citizen children who provide their Social Security Number are not required to provide identity or citizenship documentation if eligible for Child Health Plus.

  Children who are New York State residents and do not have other health insurance are eligible, regardless of their immigration status.

PUBLIC CHARGE INFORMATION

The United States Citizenship and Immigration Services (USCIS) has stated that enrollment in Medicaid, Family Health Plus, Child Health Plus or the Family Planning Benefit Program CANNOT affect a person's ability to get a green card, become a citizen, sponsor a family member, or travel in and out of the country. This is not true if Medicaid pays for long-term care in a place such as a nursing home or psychiatric hospital.

The State will not report any information on this application to the USCIS.

- Race/Ethnic Group. This information is optional and it will help us make sure that all people have access to the programs. If you fill out this information, use the code shown on the application that best describes each person's race or ethnic background. You may pick more than one.

SECTION C Household Income (Money Received)

- In this section, list all types of income (money received) and the amounts received by the people you listed in Section B.
- Please tell us how much you make before taxes are taken out.
- If there is no money coming into your home, explain how you are paying for your living expenses, such as food and housing.
- We need to know if you have changed jobs or if you are a student.
- We also need to know if you pay another person or place, such as a day care center, to take care of your children or disabled spouse or parent while you are working or going to school. If you do, we need to know how much you pay. We may be able to deduct some of the amount that you pay for these costs from the amount we count as your income.

SECTION D Health Insurance

It is important to tell us whether anyone applying is covered or could be covered by someone else's health insurance. This information may affect their eligibility for coverage; for some applicants, we can deduct the amount that you pay for health insurance from the amount we count as your income; or we may be able to pay the cost of your health insurance premium if we determine it is cost effective.

Some children who had employer-based health insurance within the past six months may be subject to a waiting period before they can enroll in Child Health Plus. This will depend on your household income and the reason your children lost employer-based coverage.

NOTE: State Health Benefits Plans provide health insurance coverage through the New York State Health Insurance Program (NYSHIP). Coverage is offered to employees/retirees of NYS government, the State Legislature and the Unified Court System. Some local government agencies and school districts also elect to participate in NYSHIP. If you are not sure, check with your employer. If your child has access to State Health Insurance Benefits through NYSHIP, he/she will be ineligible for Child Health Plus coverage.

We may be able to help pay for health insurance premiums if you have or can get insurance through your job. We will need to gather more information about the insurance and will mail an insurance questionnaire to you.

SECTION E Housing Expenses

Write in your monthly cost of housing. This includes your rent, monthly mortgage payment or other housing payment. If you have a mortgage payment, include property taxes in the amount you tell us. If you share your housing expenses or your rent is subsidized, please only tell us how much YOU pay toward your rent or mortgage. If you pay for your water, tell us how much you pay and how often.

SECTION F Blind, Disabled, Chronically Ill or Nursing Home Care

These questions help us determine which program is best for each applicant, and what services may be needed. A person with a disability, serious illness or high medical bills may be able to get more health services. You may have a disability if your daily activities are limited because of an illness or condition that has lasted or is expected to last for at least 12 months. If you are blind, disabled, chronically ill or need nursing home care, you will need to complete Supplement A. If neither you nor anyone applying is blind, disabled, chronically ill or in a nursing home, go to Section G.

SECTION G Additional Health Questions

If you have paid or unpaid medical bills from the past three months, Medicaid may be able to pay for these costs. Let us know who these bills are for and in which months. Include copies of the medical bills with this application. Note: This three-month period begins when the local department of social services receives your application or when you meet with a Facilitated Enroller. You will need to tell us what your income was for any past months in which you have medical bills so that we can see if you are eligible during that time. We also ask about where you lived in the past three months, because this may affect our ability to pay for past bills. We ask about any pending lawsuits or health issues caused by someone else so we know if someone else should pay for any portion of your medical care costs.

SECTION H Parent or Spouse Not Living in the Household or Deceased

- **If any applicants have an absent spouse or parent, you must complete this section so we can see if medical support is available to you or your child.**
- **Pregnant women do not have to answer these questions until 60 days after the birth of their child.** All other people who are applying and are age 21 or over must be willing to provide information about a parent of an applying minor or a spouse living outside the home to be eligible for health insurance, unless there is good cause. An example of "good cause" is fear of physical or emotional harm to you or a family member. Question 2 refers to the **PARENT** of any applying child under age 21. Question 3 refers to the **SPOUSE** of anyone applying.
- If the parents are not willing to provide this information, the applying child may still be eligible for Medicaid or Child Health Plus.

SECTION I Health Plan Selection

What is a Health Plan? Applying for programs through Access NY Health Care may mean you get your health care coverage through a Managed Care plan. When you join a plan, you choose one doctor (Primary Care Provider or PCP) from that plan to take care of your regular needs. If you want to keep the doctor you have, you need to pick the plan that works with your doctor. Managed Care health plans focus on preventive care so small problems do not become big ones. If you need a specialist, your PCP will refer you to one.

Who Must Choose a Health Plan? People who are eligible for Family Health Plus and Child Health Plus **MUST** choose a health plan to get medical care. **MOST** people who are eligible for Medicaid **MUST** choose a health plan to get most of their Medicaid benefits. Keep reading to find out how to get more information on this.

How Do I Know What Health Plan to Choose and If I Can Enroll? For Medicaid and Family Health Plus, if you want to find out more about how managed care plans work, if you have to join, and how to choose a plan, call **Medicaid CHOICE** at **1-800-505-5678,** or call or visit your local department of social services. Ask for a Managed Care Education Packet. Information about health plans is also on the NYSDOH website at **www.nyhealth.gov.** You can also enroll by phone, by calling **1-800-505-5678.**

NOTE: If you or a family member are found eligible for Medicaid, and are in a county that does not require people on Medicaid to join a health plan, you will still be enrolled in the health plan you choose if it provides Medicaid, unless you check the box on the application that says you don't want to be enrolled, or tell us you do not want to be enrolled by calling or writing to your local department of social services.

For Child Health Plus:

For information about Child Health Plus plans, call **1-800-698-4543.**

Child Health Plus Premium

There are no premiums for Medicaid, or Family Health Plus. There may be a monthly premium for Child Health Plus. Use the enclosed chart to determine if you need to pay a premium based on your monthly income. You must include the first month's premium with the completed application or your child will not be enrolled.

SECTION J Signature

Please read the paragraph in this section carefully and read the **Terms, Rights and Responsibilities** section. You must then sign and date the application.

State of New York
Department of Health

ACCESS NY HEALTH CARE Medicaid / Family Health Plus / Child Health Plus

PLEASE READ the entire application and INSTRUCTIONS before you fill it out. Print clearly in blue or black ink. An incomplete application cannot be processed and will result in a delay of a decision on your application.

Section A Applicant's Information

Please tell us who you are and how to contact you.

Legal First Name	Middle Initial	Legal Last Name

Primary Phone #	Another Phone #	What Language Do You
☐ Home ☐ Cell ☐ Work ☐ Other	☐ Home ☐ Cell ☐ Work ☐ Other	Speak? _____ Read? _____

HOME ADDRESS SEND PROOF
of the persons applying for health insurance
☐ Check here if homeless

Street		Apt.#	
City	State	Zip Code	County

MAILING ADDRESS
of the persons applying for health insurance if different from above.

Street		Apt.#	
City		State	Zip Code

OPTIONAL: If there is another person you would like to receive your Medicaid notices, please provide this person's contact information.
I want this contact person to:

Check all that apply
☐ Apply for and/or renew Medicaid for me
☐ Discuss my Medicaid application or case, if needed
☐ Get notices and correspondence

Name		State
Street	Apt.#	Zip Code
City		Phone # ☐ Home ☐ Cell ☐ Work ☐ Other

Section B Household Information

If you live in the household, start with yourself. If you do not, start with any adults who live in the household. List the full legal names of the persons applying for or already receiving Medicaid, Family Health Plus or Child Health Plus **and list the ID Number from their Benefit Card or health plan ID card.** You **must** provide information for household members including: parents, step-parents, and spouses. You may provide information for other household members (for example, a dependent child under the age of 21).
Listing other household members may allow us to give you a higher eligibility level. Pregnant women and children under 19 may be eligible for health insurance regardless of immigration status.

	Legal First, Middle, Last Name	Date of Birth SEND PROOF	Is this person applying for health insurance?	Is this person pregnant? SEND PROOF	Is this person the parent of an applying child?	What is the relationship to the person in Box 1?	If this person has or had public health coverage in the past, check the box that applies.	Social Security Number (if you have one)	Please mark one box that indicates your current Citizenship or Immigration Status. Not needed for pregnant women SEND PROOF	*Race/ Ethnic Group
01	_____ Full Maiden Name (person's birth name before they were married) City of Birth State of Birth Country of Birth This Person's Mother's Full Maiden Name	/ / ☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No What is the Due Date? / /	☐ Yes ☐ No	SELF	☐ Child Health Plus ☐ Medicaid ☐ Family Health Plus ID Number from Benefit Card/Plan Card, if known:		☐ U.S. Citizen ☐ Immigrant/non-citizen Enter the date you received your immigration status _____/_____/_____ Month Day Year ☐ Non-immigrant (Visa holder) ☐ None of the above	
02	_____ Full Maiden Name (person's birth name before they were married) City of Birth State of Birth Country of Birth This Person's Mother's Full Maiden Name	/ / ☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No What is the Due Date? / /	☐ Yes ☐ No		☐ Child Health Plus ☐ Medicaid ☐ Family Health Plus ID Number from Benefit Card/Plan Card, if known:		☐ U.S. Citizen ☐ Immigrant/non-citizen Enter the date you received your immigration status _____/_____/_____ Month Day Year ☐ Non-immigrant (Visa holder) ☐ None of the above	

Effective 7/1/10, citizen children who provide a SSN are not required to provide identity or citizenship documentation if eligible for Child Health Plus.

SEND PROOF **Refer to the "Documents Needed When You Apply for Health Insurance" in the instructions on pages 1-3, "Documentation Checklist for Health Insurance", for a list of documents that prove Identity, Citizenship or Immigration Status.**

***Race/Ethnic Group Codes (optional):** A-Asian, B-Black or African-American, I- Native American or Alaskan Native, P- Native Hawaiian or other Pacific Islander, W-White, U-Unknown. Please also tell us if you are Hispanic or Latino-H

Section B Household Information (Continued from previous page)

	Legal First, Middle, Last Name	Date of Birth SEND PROOF	Is this person applying for health insurance?	Is this person pregnant? SEND PROOF	Is this person the parent of an applying child?	What is the relationship to the person in Box 1?	If this person has or had public health coverage in the past, check the box that applies.	Social Security Number (if you have one)	Please mark one box that indicates your current Citizenship or Immigration Status. Not needed for pregnant women SEND PROOF	*Race/ Ethnic Group
03	Full Maiden Name (person's birth name before they were married) City of Birth State of Birth Country of Birth This Person's Mother's Full Maiden Name	/ / ☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No What is the Due Date? / /	☐ Yes ☐ No		☐ Child Health Plus ☐ Medicaid ☐ Family Health Plus ID Number from Benefit Card/Plan Card, if known:		☐ U.S. Citizen ☐ Immigrant/non-citizen Enter the date you received your immigration status ____/____/____ Month Day Year ☐ Non-immigrant (Visa holder) ☐ None of the above	
04	Full Maiden Name (person's birth name before they were married) City of Birth State of Birth Country of Birth This Person's Mother's Full Maiden Name	/ / ☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No What is the Due Date? / /	☐ Yes ☐ No		☐ Child Health Plus ☐ Medicaid ☐ Family Health Plus ID Number from Benefit Card/Plan Card, if known:		☐ U.S. Citizen ☐ Immigrant/non-citizen Enter the date you received your immigration status ____/____/____ Month Day Year ☐ Non-immigrant (Visa holder) ☐ None of the above	
05	Full Maiden Name (person's birth name before they were married) City of Birth State of Birth Country of Birth This Person's Mother's Full Maiden Name	/ / ☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No What is the Due Date? / /	☐ Yes ☐ No		☐ Child Health Plus ☐ Medicaid ☐ Family Health Plus ID Number from Benefit Card/Plan Card, if known:		☐ U.S. Citizen ☐ Immigrant/non-citizen Enter the date you received your immigration status ____/____/____ Month Day Year ☐ Non-immigrant (Visa holder) ☐ None of the above	
06	Full Maiden Name (person's birth name before they were married) City of Birth State of Birth Country of Birth This Person's Mother's Full Maiden Name	/ / ☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No What is the Due Date? / /	☐ Yes ☐ No		☐ Child Health Plus ☐ Medicaid ☐ Family Health Plus ID Number from Benefit Card/Plan Card, if known:		☐ U.S. Citizen ☐ Immigrant/non-citizen Enter the date you received your immigration status ____/____/____ Month Day Year ☐ Non-immigrant (Visa holder) ☐ None of the above	
07	Full Maiden Name (person's birth name before they were married) City of Birth State of Birth Country of Birth This Person's Mother's Full Maiden Name	/ / ☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No What is the Due Date? / /	☐ Yes ☐ No		☐ Child Health Plus ☐ Medicaid ☐ Family Health Plus ID Number from Benefit Card/Plan Card, if known:		☐ U.S. Citizen ☐ Immigrant/non-citizen Enter the date you received your immigration status ____/____/____ Month Day Year ☐ Non-immigrant (Visa holder) ☐ None of the above	

Is anyone in your household a veteran? ☐ Yes ☐ No If yes, name: _____

Effective 7/1/10, citizen children who provide a SSN are not required to provide identity or citizenship documentation if eligible for Child Health Plus.

SEND PROOF **Refer to the "Documents Needed When You Apply for Health Insurance" in the instructions on pages 1-3, "Documentation Checklist for Health Insurance", for a list of documents that prove Identity, Citizenship or Immigration Status.**

***Race/Ethnic Group Codes (optional):** A-Asian, B-Black or African-American, I- Native American or Alaskan Native, P- Native Hawaiian or other Pacific Islander, W-White, U-Unknown. Please also tell us if you are Hispanic or Latino-H

Section C Household Income

Write the types of money and the amount received by everyone listed in Section B and **SEND PROOF**

Earnings from Work: Includes wages, salaries, commissions, tips, overtime, self-employment. If you are self-employed check here: ☐ Check here if no earnings from work: ☐

Name of Person	Type of Income/Employer Name	How Much? (before taxes)	How Often? (weekly, monthly)

Unearned Income: Includes Social Security Benefits, disability payments, unemployment payments, interest and dividends, veterans' benefits, Workers' Compensation, child support payments/alimony, rental income, pension, annuities and trust income. Check here if no unearned income: ☐

Name of Person	Type of Income/Source	How Much? (before taxes)	How Often? (weekly, monthly)

Contributions: Money from relatives or friends, roomers or boarders (include money that anyone gives you each month to help meet living expenses). Check here if no contributions: ☐

Name of Person	Type of Income/Source	How Much? (before taxes)	How Often? (weekly, monthly)

Other: Temporary (cash) Assistance, Supplemental Security Income (SSI) payments, student grants, or loans. Check here if none: ☐

Name of Person	Type of Income/Source	How Much? (before taxes)	How Often? (weekly, monthly)

1. Do you or any applying adult in Section B have no income? ☐No ☐ Yes Who? _____

2. If there is no income listed above, please explain how you are living:
(For example: living with friend or relative)

3. Have you or anyone who is applying changed jobs or stopped working in the last 3 months? ☐No ☐ Yes
If yes: Your last job was: Date _____/_____/_____ Name of Employer:

4. Are you or anyone who is applying a student in a vocational, undergraduate, or graduate program? ☐No ☐ Yes
If yes: ☐ Full Time ☐ Part Time ☐ Undergraduate ☐ Graduate Student's Name:

5. Do you have to pay for childcare (or for care of a disabled adult) in order to work or go to school? ☐No ☐ Yes

Child's/adult's name:	How much? $	How Often? (weekly, every two weeks, monthly)
Child's/adult's name:	How much? $	How Often? (weekly, every two weeks, monthly)
Child's/adult's name:	How much? $	How Often? (weekly, every two weeks, monthly)

6. If you are not eligible for Medicaid or Family Health Plus coverage, you may still be eligible for the Family Planning Benefit Program. Are you interested in receiving coverage for Family Planning Services only? ☐ No ☐ Yes

Section D Health Insurance

You and your family may still be eligible even if you have other health insurance.

1. Does anyone who is applying have Medicare? ☐ No ☐ Yes **If yes, include a copy of your card (red, white and blue card), for each Medicare beneficiary.** SEND PROOF **Complete the rest of this application and complete Supplement A.**

2. Does anyone who is applying already have other commercial health insurance, including long term care insurance? ☐ No ☐ Yes **If yes, you must send a copy of the front and back of the insurance card with this application.** SEND PROOF

   Name of Insured (primary) _____ Persons Covered _____ Cost of Policy _____ End date of coverage, if ending soon _____/_____/_____ (Month Day Year)

   Note: If you are applying for the Medicare Savings Program only (MSP), go to Section G. You do NOT need to complete Supplement A.

3. Is the parent/step-parent of any child applying a public employee who can get family coverage through a state health benefits plan? (see instructions) ☐ No ☐ Yes
   If yes, does the public agency where that person works pay all or part of the cost of the health plan? ☐ No ☐ Yes

4. In the past 6 months, has anyone lost or cancelled any type of health insurance that was provided through an employer? ☐ No ☐ Yes (If no, skip to question 5) If yes, what date did you lose coverage? _____/_____/_____ (Month Day Year)

   Your answer to this question will help us understand why people change their health insurance.

   Why do the person(s) no longer have the health insurance? (Check only one)

   ☐ 1. The person who had the insurance no longer works for the employer that provided the insurance.
   ☐ 2. The employer stopped offering health insurance.
   ☐ 3. The employer stopped offering health insurance for the child(ren) or stopped paying for health insurance for the child(ren) but continued to cover the working parent.
   ☐ 4. The cost of health insurance went up and it was no longer affordable.
   ☐ 5. Child Health Plus or Family Health Plus costs less than the insurance the person(s) used to have.
   ☐ 6. Child Health Plus or Family Health Plus offers better benefits than the insurance the person(s) used to have.

5. Does your current job offer health insurance? **We may be able to help pay for it.** ☐ No ☐ Yes If yes, a "Request for Information Employer Sponsored Health Insurance" form will be sent to you.

Section E Housing Expenses

1. Monthly housing payment **such as rent or mortgage, including property taxes** (just your share). $_____

2. If you pay for water separately how much do you pay? $_____ SEND PROOF How often do you pay? ☐ every month ☐ 2 times a year ☐ quarterly (4 times a year) ☐ once a year

3. Do you receive **free** housing as part of your pay? ☐ No ☐ Yes

Section F Blind, Disabled, Chronically Ill or Nursing Home Care

These questions help us determine which program is best for the applicants.

If no one applying is Blind, Disabled, Chronically Ill or in a Nursing Home STOP please go to Section G.

1. Are you, or anyone who lives with you, and is applying, in a residential treatment facility or receiving **nursing home care** in a hospital, nursing home or other medical institution? ☐ No ☐ Yes
   If yes, finish completing this application **AND** complete Supplement A.

2. Are you or anyone who lives with you blind, disabled or chronically ill? ☐ No ☐ Yes If yes, finish completing this application **AND** complete Supplement A.
   Note: If you are applying for the Medicare Savings Program only (MSP), go to Section G. You do not need to complete Supplement A.

Section G Additional Health Questions

1. Does anyone applying have paid or unpaid medical or prescription bills for this month or the three months before this month? Medicaid may be able to pay these bills or reimburse you.

☐ No ☐ Yes If yes: Name: _____ In which month(s) of the previous three months do you have medical bills? _____

SEND PROOF **of income for any month in the three-month period for which you have bills. If you have paid medical bills for which you are seeking reimbursement, you must send copies and proof of payment.**

2. Do you, or anyone applying, have any unpaid medical or prescription bills older than the previous three months? ☐ No ☐ Yes

3. Have you, or anyone who lives with you and is applying, moved into this county from another state or New York State county within the past three months? ☐ No ☐ Yes

If yes, who? _____ Which state? _____ Which county? _____

4. Does anyone who is applying have a pending lawsuit due to an injury? ☐ No ☐ Yes If yes, who: _____

5. Does anyone applying have a Workers' Compensation case or an injury, illness, or disability that was caused by someone else (that could be covered by insurance)? ☐ No ☐ Yes

If yes, who? _____

Section H Parent or Spouse Not Living in the Household or Deceased

Families who are applying for their children and pregnant women are **NOT** required to fill out this section. All other people who are applying and are age 21 or over must be willing to provide information about a parent of an applying minor or a spouse living outside the home to be eligible for health insurance, unless there is good cause. Children may still be eligible even if a parent is not willing to provide this information. If you fear physical or emotional harm as a result of providing information about a parent or spouse not living in the home, you may be excused from providing this information. This is called **Good Cause.** You may be asked to show that you have a good reason for your fears.

1. Is the spouse or parent of anyone applying deceased? ☐ No ☐ Yes

If yes, name of applicant with deceased parent or spouse : _____ (If spouse or parent is deceased go to question 3.)

2. Does a parent of any applying child live outside the home? (If no, skip to question 3) ☐ No ☐ Yes

If you fear physical or emotional harm if you provide information about a parent who does not live in the home, check this box ☐

Child's Name:	**Name of parent living outside the home** _____ Date of Birth (if known): _____/_____/_____	**Current or last known address:** Street: _____ City/State: _____ SSN (if known): _____
Child's Name:	**Name of parent living outside the home** _____ Date of Birth (if known): _____/_____/_____	**Current or last known address:** Street: _____ City/State: _____ SSN (if known): _____

3. Is anyone applying still married to someone who lives outside the home? ☐ No ☐ Yes If yes, name of person applying who is still married: _____

If you fear physical or emotional harm if you provide information about a spouse who does not live in the home, check this box ☐

Legal name of spouse living outside of the home:	**Date of Birth (if known):**	**Current or last known address:** Street: _____ City/State: _____ SSN (if known): _____

Section I Health Plan Selection

If you are in receipt of Medicare, STOP skip this section.

IMPORTANT: People with Family Health Plus and Child Health Plus **must** choose a health plan to get their health services. Most people with Medicaid **must** choose a health plan; if you don't choose a health plan you may be automatically enrolled in one unless it is determined you are exempt. **For Medicaid and Family Health Plus:** If you need information about what plans are available in your county, what plans your doctor is in and if you have to join, please call **New York Medicaid CHOICE** at 1-800-505-5678. You can also call or visit your local Department of Social Services. For information about Child Health Plus plans, call 1-800-698-4543. If you already know what plan you want, use this section for your plan choice.

NOTE: If you or family members are found eligible for Medicaid, you will be enrolled in the health plan you choose if it provides Medicaid. If you live in a county that does not require people on Medicaid to join a health plan, you can tell us you do not want to be in a health plan by calling or writing to your local Department of Social Services or by checking this box ☐

Legal Last Name	Legal First Name	Date of Birth	Social Security #	Name of Health Plan You are Enrolling in	Preferred Doctor or Health Center (optional) Check Box if Your Current Provider	OB/GYN (optional)
					☐	
					☐	
					☐	
					☐	
					☐	
					☐	

Section J Signature

I agree to have the information on this application and on the annual renewal shared only among Medicaid, Family Health Plus, Child Health Plus, the health plans indicated in Section I, the local social services district, and the facilitated enrollment organization providing the application assistance. I also consent to sharing this information with any school-based health center that provides services to the applicant(s). I understand this information is being shared for the purpose of determining the eligibility of those individuals applying for Medicaid, Family Health Plus, Child Health Plus, or to evaluate the success of these programs. Each applying adult must sign this application in the space below. By signing this application, I understand that each person applying for Medicaid, Family Health Plus, Child Health Plus, will be enrolled in the appropriate program, if eligible. **I have also read and understand the Terms, Rights and Responsibilities included in this application booklet on the next page.** I certify under penalty of perjury that everything on this application is the truth as best I know.

Date _____ *Signature of adult applicant or authorized representative for the applicant* _____

Date _____ *Signature of adult applicant or authorized representative for the applicant* _____

TERMS, RIGHTS AND RESPONSIBILITIES

By completing and signing this application, I am applying for Medicaid, Family Health Plus, and Child Health Plus. I understand that this application, notices and other supporting information will be sent to the program(s) for which I want to apply. I agree to the release of personal and financial information from this application and any other information needed to determine eligibility for these programs. I understand that I may be asked for more information. I agree to immediately report any changes to the information on this application.

- I understand that I must provide the information needed to prove my eligibility for each program. If I have been unable to get the information for Medicaid or Family Health Plus, I will tell the social services district. The social services district may be able to help in getting the information.
- If I am applying at a place other than a local department of social services, and my children are not found eligible for Medicaid using this application, I can contact the local department of social services to see if my children are eligible for Medicaid on some other basis.
- I understand that workers from the programs for which family members or I have applied may check the information given by me for this application. The agencies that run these programs will keep this information confidential according to 42 U.S.C. 1396a (a) (7) and 42 CFR 431.300-431.307, and any federal and state laws and regulations.
- By applying for Child Health Plus, I agree to pay the applicable premium contribution not paid by New York State.
- I understand that Medicaid, Family Health Plus, and Child Health Plus will not pay medical expenses that insurance or another person is supposed to pay, and that if I am applying for Medicaid or Family Health Plus, I am giving to the agency all of my rights to pursue and receive medical support from a spouse or parents of persons under 21 years old and my right to pursue and receive third party payments for the entire time I am in receipt of benefits.
- I will file any claims for health or accident insurance benefits or any other resources to which I am entitled. I understand that I have the right to claim good cause not to cooperate in using health insurance if its use could cause harm to my health or safety or to the health and safety of someone I am legally responsible for.
- I understand that my eligibility for these programs will not be affected by my race, color, or national origin. I also understand that depending on the requirements of these individual programs, my age, sex, disability or citizenship status may be a factor in whether or not I am eligible.
- I understand that if my child is on Medicaid or Family Health Plus, he or she can get comprehensive primary and preventive care, including all necessary treatment through the Child/Teen Health Program. I can get more information on this program from the local department of social services.
- I understand that anyone who knowingly lies or hides the truth in order to receive services under these programs is committing a crime and subject to federal and state penalties and may have to repay the amount of benefits received and pay civil penalties. The New York State Department of Tax and Finance has the right to review income information on this form.

SOCIAL SECURITY NUMBER

Child Health Plus: SSNs are not required to enroll in Child Health Plus. If available, I will include it for children applying for Child Health Plus.

Medicaid, or Family Health Plus: SSNs are required for all applicants, unless the person is pregnant or a non-qualified alien. SSNs are not required for members of my household who are not applying for benefits. I understand that this is required by Federal Law at 42 U.S.C. 1320b-7 (a) and by Medicaid regulations at 42 CFR 435.910. SSNs are used in many ways, both within department of social services (DSS) and between the DSS and federal, state, and local agencies, both in New York and other jurisdictions. Some uses of SSNs are: to check identity, to identify and verify earned and unearned income, to see if non-custodial parents can get health insurance coverage for applicants, to see if applicants can get medical support, and to see if applicants can get money or other help. SSNs may also be used for identification of the recipient within and between central governmental Medicaid agencies to insure proper services are made available to the recipient. Also, if I apply for other programs in this joint application, those programs will have access to my SSN and could use it in the administration of the program.

FOR MEDICAID APPLICANTS ONLY

- **Release of Educational Records**
  I give permission to the local department of social services and New York State to obtain any information regarding the educational records of my child(ren), herein named, necessary for claiming Medicaid reimbursements for health-related educational services, and to provide the appropriate federal government agency access to this information for the sole purpose of audit.
- **Early Intervention Program**
  If my child is evaluated for or participates in the New York State Early Intervention Program, I give permission to the local separtment of social services and New York State to share my child's Medicaid eligibility information with my county Early Intervention Program for the purpose of billing Medicaid.

- **Reimbursement of Medical Expenses**
  I understand that I have a right as part of my Medicaid application, or later, to request reimbursement of expenses I paid for covered medical care, services and supplies received during the three month period prior to the month of my application. After the date of my application, reimbursement of covered medical care, services and supplies will only be available if obtained from Medicaid enrolled providers.

FAMILY HEALTH PLUS AND MEDICAID MANAGED CARE

I understand that in order to receive Family Health Plus benefits, I must join a managed care health plan. I also know that in some counties, joining a health plan may be required to receive Medicaid. I have read how to find out whether my county requires Medicaid enrollees to join a health plan, and how to find out what health plans are available to me in Family Health Plus and in Medicaid managed care. I understand that if I am found eligible for Family Health Plus, I will be enrolled in the Family Health Plus plan I have chosen. I/we also understand that if I/we are found eligible for Medicaid instead of Family Health Plus and I/we are in a county that requires Medicaid enrollees to be in a managed care health plan, I/we will be enrolled in the health plan I/we chose unless that health plan does not participate in Medicaid managed care. If I/we are in a county that does not require enrollees to be in a Medicaid managed care health plan, I/we will still be enrolled in the health plan I/we chose unless I/we notify my local social services department in writing, or I/we check the box in Section I, that I/we do not want to be in that plan.

I have read how to find out the rights and benefits that I will have as a member of a managed care health plan and the benefit limitations of managed care membership.
I understand that in both Family Health Plus and Medicaid managed care, I must choose a Primary Care Provider (PCP) and that I will have a choice from at least three PCPs in my health plan. I understand that once I enroll in a health plan, I will have to use my PCP and other providers in my health plan except in a few special circumstances.

I understand that if a child is born to me while I am a member of a Medicaid managed care health plan, my child will be enrolled in the same health plan that I am in.
I understand that if a child is born to me while I am a member of a Family Health Plus plan that also participates in Medicaid managed care, my child will be enrolled in the same health plan that I am in.

- **Release of Medical Information**
  I consent to the release of any medical information about me and any members of my family for whom I can give consent:
  - By my PCP, any other health care provider or the New York State Department of Health (NYSDOH) to my health plan and any health care providers involved in caring for me or my family, as reasonably necessary for my health plan or my providers to carry out treatment, payment, or health care operations. This may include pharmacy and other medical claims information needed to help manage my care;
  - By my health plan and any health care providers to NYSDOH and other authorized federal, state, and local agencies for purposes of administration of the Medicaid, Child Health Plus, and Family Health Plus programs; and
  - By my health plan to other persons or organizations, as reasonably necessary for my health plan to carry out treatment, payment, or health care operations.

I also agree that the information released for treatment, payment and health care operations may include HIV, mental health or alcohol and substance abuse information about me and members of my family to the extent permitted by law, until I revoke this consent.

If more than one adult in the family is joining a Family Health Plus or Medicaid health plan, the signature of each adult applying is necessary for consent to release information.

- **Reimbursement of Medical Expenses**
  I understand that if I am determined eligible for Family Health Plus my enrollment will be effective no later than 90 days from the date of submission of a completed application. In the event of an error or delay in my enrollment, Medicaid may be able to reimburse me for reasonable medical expenses I pay as a result of the error or delay. Medicaid may pay my provider for any unpaid expenses only if that provider is a Medicaid enrolled provider.

FOR OFFICE USE ONLY

To be completed by the person assisting with the application

Signature of Person Who Obtained Eligibility Information: X _____	Employed By: (check one) ☐ Community-Based Facilitated Enrollment Agency ☐ Health Plan ☐ Social Services District ☐ Provider Agency ☐ Qualified Entities Employer Name: _____

To be completed by Facilitated Enrollers

Facilitated Enroller:		Lead Agency/Plan Name:		Lead Org/Plan ID:
Language Used for Application Assistance:	Application Start Date:	Application Sequence Number:	Application Completion Date:	Enter Code of Applying Child: Medicaid _____ CHPlus _____

To be used by the local Social Services District

Eligibility Determined By:	Date:	Eligibility Approved By:		Date:
Center Office:	Application Date:	Unit ID:		Worker ID:
Case Name:	District:	Case Type:		Case #:
Effective Date:	MA Disposition Reason Code: ☐ Denial Code ☐ Withdrawal	Proxy: ☐ Yes ☐ No	Registry #:	Ver:

To be used by Child Health Plus Plans

CHPlus Disposition: ☐ Approved ☐ Denied	Denial Code:	Effective Date:	# Children Enrolled (CHPlus):

Health Insurance

Health insurance is available for most uninsured children under age 19, living in New York State under one of two programs: Medicaid or Child Health Plus. Almost all children are eligible, regardless of how much your family earns or your child's immigration status.

Health insurance is available under Medicaid and Family Health Plus for most people aged 19 to 64, who have limited income and who are citizens or fall within one of many immigration categories. Also, for people who are age 65 or older, certified blind or certified disabled who have limited income and resources and who are citizens or who fall within one of many immigration categories, health insurance is available under Medicaid.

What programs am I eligible for?

One application is used to apply for the following programs: Medicaid, Family Health Plus, Child Health Plus, and the Family Planning Benefit Program. Based on the information you give us, we will tell you which program you and/or your children may be eligible for.

What services are covered?

Important services such as regular medical check-ups, prescription drugs, hospital care, eye exams, eyeglasses, mental health services, and much more are covered. Medicaid and Family Health Plus have an added guarantee for persons under the age of 21, that provides for all necessary treatment through the Child/Teen Health Program. There are no deductibles or co-payments for children's health insurance.

The chart below shows the amount of income (before taxes) at which you can get free or subsidized health insurance. For children under 19, if your income is more than these amounts, your child can get health insurance for a higher cost.

MONTHLY INCOME LIMITS				RESOURCE LIMITS
FAMILY SIZE	ADULTS	CHILDREN UNDER AGE 19	PREGNANT WOMEN	PERSONS AGE 65 OR OLDER CERTIFIED BLIND OR CERTIFIED DISABLED ONLY
1	$903	$3,610	*	$13,800
2	$1,822	$4,857	$2,429	$20,100
3	$2,289	$6,104	$3,052	$23,115
4	$2,757	$7,350	$3,675	$26,130
5	$3,224	$8,597	$4,299	$29,145
6	$3,692	$9,844	$4,922	$32,160
7	$4,159	$11,090	$5,545	$35,175
8	$4,627	$12,337	$6,169	$38,190

Note: Effective January 1, 2009. Income levels change annually. This is just a guide. Adults without children may have a lower income level. *Pregnant women count as 2 when determining family size.

Do I have to pay anything to join?

How much you pay depends on your family income. For most families, health insurance is free. Other families have to pay a small amount.

How will I get my medical services?

People eligible for Family Health Plus and Child Health Plus will receive their health care through health plans that have their own groups of doctors and hospitals. Before joining a plan, make sure your doctors are a part of that plan.

Most people eligible for Medicaid MUST also choose a health plan. They will receive their health care through the health plan. In some areas of the state there may not be health plans. In these areas, people may go to any doctor who accepts Medicaid. You should talk to your doctor about what kind of health insurance he/she accepts.

What do I have to do to enroll?

It's now easier than ever to apply for health insurance. There are a lot of places in your neighborhood where you can get help. These places have experienced and friendly staff that are available on weekends and evenings to answer all of your questions and help you apply.

It is no longer necessary to have a personal interview to enroll in Medicaid or Family Health Plus. Your completed application can be mailed to or dropped off at your local department of social services. If you are only applying for Child Health Plus, you can mail your completed application directly to a Child Health Plus health plan.

What is available for pregnant women?

New York State provides free health insurance under Medicaid for many pregnant women with limited income regardless of their immigration status. Pregnant women who participate in Medicaid can receive a wide range of services designed to ensure a healthy pregnancy, including prenatal visits, health education, and specialty medical care. Services continue until two months after the pregnancy ends. Family planning services are available for up to 24 months after the pregnancy ends. After the baby is born, he or she will automatically receive health insurance for a year.

What is the Family Planning Benefit Program?

This program covers health services and related drugs and supplies to maintain good reproductive health. Men and women of childbearing age may be eligible.

For Help Call:

To learn the nearest location where application assistance is available in your area, call:

For adults: 1-877-9FHPLUS
For children: 1-800-698-4543

CHILD HEALTH PLUS PREMIUM							
Family Size	Free	$9 per Child per Month (max $27)	$15 per Child per Month (max $45)	$30 per Child per Month (max $90)*	$45 per Child per Month (max $135)*	$60 per Child per Month (max $180)*	Full Premium per Child
1	$1,443	$2,004	$2,257	$2,708	$3,159	$3,610	OVER $3,610
2	$1,942	$2,696	$3,036	$3,643	$4,250	$4,857	OVER $4,857
3	$2,441	$3,388	$3,815	$4,578	$5,341	$6,104	OVER $6,104
4	$2,939	$4,080	$4,594	$5,513	$6,432	$7,350	OVER $7,350
5	$3,438	$4,772	$5,373	$6,448	$7,523	$8,597	OVER $8,597
For each additional person Add:	$499	$692	$780	$935	$1091	$1247	

*Effective July 1, 2009. Income levels change annually. Note that coverage for children under age one is free at higher income levels.

For New York State Residents outside of New York City

Supplement A

(Supplement to Access NY Health Care Application DOH-4220)

This Supplement must be completed if anyone who is applying is:

- Age 65 or older
- Certified blind or certified disabled (of any age)
- Not certified disabled but chronically ill
- Institutionalized and applying for coverage of nursing home care.
  This includes care in a hospital that is equivalent to nursing home care.

Note: If you are applying for the Medicare Savings Program (MSP) only, this Supplement does not need to be completed.

INSTRUCTIONS:

- Sections A through E must be completed and this Supplement must be signed.
- If you or anyone in your household is applying for coverage of nursing home care, you must also complete sections F through G.

A. Applicant and Spouse Information

1. Applicant(s) this Supplement is being completed for:

Legal Last Name	Legal First Name	MI	Marital Status	Social Security Number	Date of Birth	If Deceased, List Date of Death
					/ /	/ /
					/ /	/ /

Is a person named above:

- Chronically ill? ☐ Yes ☐ No
  (Examples of chronically ill would be unable to work for at least 12 months because of an illness or injury, or having an illness or disabling impairment that has lasted or is expected to last for 12 months.)

- Certified Blind by the Commission for the Blind and Visually Handicapped? ☐ Yes ☐ No
  (If yes, send proof.)

- Interested in applying for the MBI-WPD program if disabled and working? ☐ Yes ☐ No
  The Medicaid Buy-In for Working People with Disabilities (MBI-WPD) program offers Medicaid coverage to people who are disabled, working, and at least 16 years old but not yet 65 years old. The program allows higher income levels than the regular Medicaid program so working people with disabilities can earn more and keep their Medicaid coverage.

For New York State Residents outside of New York City

If an applicant is living in a long-term care facility/nursing home, adult home, or assisted living facility, provide the following information.

Name of Applicant who is in Facility	Name of Facility	Date Admitted / /	Telephone Number ( ) -
Street Address	City	State	Zip Code
Applicant's Previous Address	City	State	Zip Code

If the above previous address was also a facility or adult home, list the address prior to admission below.

Applicant's Second Previous Address	City	State	Zip Code

2. Applicant's Spouse: (if not listed above)

Legal Last Name	Legal First Name	MI
Maiden Name or Other Name Known By:	Social Security Number	Date of Birth / /
Street Address (if in a facility, list spouse's address prior to being admitted to facility)		
City	State	Zip Code

Is the applicant's spouse living in a long-term care facility/nursing home? ☐ Yes ☐ No

If **yes**, provide the following information:

Name of Facility		Date Admitted / /	Telephone Number ( ) -
Street Address	City	State	Zip Code

Is the applicant's spouse deceased? ☐ Yes ☐ No If **yes**, what is the date of death? _____ / _____ / _____

B. What Care and Services are you Applying for? (check the box that applies)

☐ **You are applying for Medicaid coverage but not coverage of community-based long-term care services.** You may attest to the amount of your resources. You are not required to submit documentation of your resources at this time. If a computer match shows something different than what you reported, you may be asked to submit proof at a later date.

This coverage does not include nursing home care, home care or any of the community-based long-term care services listed below.*

☐ **You are applying for coverage of community-based long-term care services.** Documentation of the **current** amount of your resources is required. However, you only need to submit documentation for certain resources at this time. See "Documentation Requirements" below for a list of these resources.

This coverage includes the following services:*

- Adult day health care
- Limited licensed home care
- Private duty nursing
- Hospice in the community
- Hospice residence program
- Assisted living program
- Consumer directed personal assistance program
- Certified Home Health Agency services
- Residential treatment facility care
- Personal emergency response services
- Personal care services
- Managed long-term care in the community
- Waiver and other services provided through a home and community-based waiver program

Note: Some examples of home and community-based programs that provide waiver and other services are Traumatic Brain Injury Program and Nursing Home Transition and Diversion Program.

☐ **You are institutionalized and applying for coverage of nursing home care.** Documentation of your resources for the **past 60 months** is required. However, you only need to submit documentation for certain resources at this time. See "Documentation Requirements" below for a list of these resources.

*You may be eligible for short-term rehabilitation services. Short-term rehabilitation services include one commencement/admission in a 12-month period of up to 29 consecutive days of nursing home care and/or certified home health care.

DOCUMENTATION REQUIREMENTS

If you are requesting coverage for **community-based long-term care services** or **nursing home care,** provide documentation for the time period indicated above for all of the following resources, if applicable.

- Life insurance policy;
- Securities, stocks, bonds, and mutual funds;
- Annuities;
- Burial agreement or fund;
- Trust document and accounts.

You do not need to send proof of any other resources at this time. This is because other resources may be verified through computer matches. If the resources you report do not match our records or cannot be verified through our records, we may ask you to submit proof of those other resources at a later date.

C. Resources/Assets

INSTRUCTIONS FOR SECTIONS 1 THROUGH 8:

- List all resources currently owned by you and/or your spouse/parent(s), including custodial accounts.
- Check the **"NONE"** box if you and/or your spouse/parent(s) do not own any of those resources.
- **If applying for coverage of nursing home care,** also list any accounts CLOSED in the **past 60 months;** include the balance at closing and provide an explanation of where the balance was transferred to or how it was spent. On a separate sheet of paper, provide an explanation of each transaction of $2,000 or more.
  Note: Medicaid retains the right to review all transactions made during the transfer look-back period.

1. Checking/Savings/Credit Union Accounts/Certificates of Deposits (CDs): ☐ NONE

Bank Name	Account Number	Name of Owner(s)	Current Account Balance	Closed Accounts	
				Date Closed	Balance at Closing
			$	/ /	$
			$	/ /	$
			$	/ /	$
			$	/ /	$
			$	/ /	$
			$	/ /	$
			$	/ /	$
			$	/ /	$
			$	/ /	$

2. Retirement Accounts (Deferred Compensation, IRA and/or Keogh): ☐ NONE

Institution Name	Account Number	Name of Owner(s)	Pay Out	Current Account Balance	Closed Accounts	
					Date Closed	Balance at Closing
			☐ Yes ☐ No	$	/ /	$
			☐ Yes ☐ No	$	/ /	$
			☐ Yes ☐ No	$	/ /	$
			☐ Yes ☐ No	$	/ /	$

3. Annuities, Stocks, Bonds, Mutual Funds: ☐ NONE

Institution/Company Name	Account Number	Name of Owner(s)	Date Purchased	Current Value	Closed Accounts	
					Date Closed or Sold	Value at Closing
				$	/ /	$
				$	/ /	$
				$	/ /	$
				$	/ /	$
				$	/ /	$
				$	/ /	$
				$	/ /	$

For New York State Residents outside of New York City

4. Life Insurance Policies: ☐ NONE

Insurance Company	Policy Number	Name of Owner(s)	Current Cash Value	Current Face Value	Cancelled Policies	
					Date Cancelled	Cash Out Value
			$	$	/ /	$
			$	$	/ /	$
			$	$	/ /	$
			$	$	/ /	$
			$	$	/ /	$

5. Burial Assets/Burial Contracts: (Include copies): ☐ NONE

a. Do you and/or your spouse have a pre-paid funeral agreement for you or anyone else in your family? ☐ Yes ☐ No

b. Do you and/or your spouse have a burial space or plot for you or anyone else in your family? ☐ Yes ☐ No

c. Do you and/or your spouse have money in a bank account set aside for a burial fund? ☐ Yes ☐ No

If **yes**, in what account(s) is your and/or your spouse's burial fund?

Bank Name and Account Number	Name of Owner(s)	Value
		$
		$
		$

d. Do you have life insurance to be used as your burial fund? ☐ Yes ☐ No

If **yes**, what is your policy number(s)? _____

If **yes**, is the full cash value to be used for your burial expenses? ☐ Yes ☐ No

e. Does your spouse have life insurance to be used as a burial fund? ☐ Yes ☐ No

If **yes**, what is the policy number(s)? _____

If **yes**, is the full cash value to be used for burial expenses? ☐ Yes ☐ No

6. Trust Accounts: If you and/or your spouse created or are the beneficiary of a trust, submit a copy of the trust, including the current schedule of trust assets. ☐ NONE

Name of Trust	Grantor	Trustee(s)	Assets	Beneficiary	Income
			$		$
			$		$
			$		$
			$		$

7. Vehicle(s): List all cars, trucks and vans. List all recreational vehicles, including campers, snowmobiles, boats and motorcycles. ☐ NONE

Name of Owner(s)	Year/Make/Model	Fair Market Value	Amount Owed	In use?	Date Sold
			$	☐ Yes ☐ No	/ /
			$	☐ Yes ☐ No	/ /
			$	☐ Yes ☐ No	/ /

For New York State Residents outside of New York City

8. List Any Other Resources:		
Resource Type	Name of Owner(s)	Value
		$
		$
		$
		$
		$
		$

D. Homestead

1. Do you and/or your spouse own or have a legal interest in your home, including a life estate? ☐ Yes ☐ No
2. If you are in a medical facility and own your home, do you intend to return to your home? ☐ Yes ☐ No

   If **no,** is anyone living in the home? ☐ Yes ☐ No

   Who is living in the home? _____

   How is this person related to you and/or your spouse? _____

   If you and/or your spouse's child (of any age) is living in the home, is the child disabled? ☐ Yes ☐ No

   Note: If there is a legal impediment that prevents you from selling this property, the property is not counted in determining Medicaid eligibility. **Send proof of legal impediment.**
3. Equity Value in Home:
   If you own your home, what is the equity value in your home? $ _____
   Note: Equity value is the fair market value less any outstanding liens, mortgages, etc.

E. Real Property (other than your home)

Do you and/or your spouse own or have a legal interest in any other real property? (Check any that apply) ☐ Yes ☐ No

☐ Rental Property ☐ Vacation Property ☐ Time Share ☐ Vacant Land ☐ Other Property Rights (In or outside of New York State)

If **yes**, provide the following information:

Name and Address of Owner(s)	Address of Property	Type of Ownership (Check one)	Equity value
		☐ Individual ☐ Joint tenancy ☐ Life estate	$
		☐ Individual ☐ Joint tenancy ☐ Life estate	$
		☐ Individual ☐ Joint tenancy ☐ Life estate	$
		☐ Individual ☐ Joint tenancy ☐ Life estate	$

STOP HERE unless you or anyone in your household is institutionalized and applying for coverage of nursing home care. However, Section I of this document MUST be signed.

F. Asset Transfers

1. Transfers

a. In the last 60 months, did you, your spouse, or someone on your behalf transfer, change ownership in, give away, or sell any assets, including your home or other real property? ☐ Yes ☐ No

b. In the last 60 months, have you or your spouse created or transferred any assets into or out of a trust? ☐ Yes ☐ No

If you answered yes to either of the questions above, explain the transfer(s) below. Attach additional sheets of paper, if needed.

Description of Asset (including income)	Date of Transfer	Transferred to Whom	Amount of Transfer
			$
			$
			$
			$

c. Are you in the process of selling property? ☐ Yes ☐ No

d. In the last 60 months, did you, your spouse or someone on your behalf, change the deed or the ownership of any real property, including creating a life estate? ☐ Yes ☐ No

If **yes**, when? _____

e. If you purchased a life estate in another person's home, did you live in the home for at least one year after you purchased the life estate? ☐ Yes ☐ No

f. In the last 60 months, did you, your spouse, or someone on your behalf purchase a mortgage, loan, or promissory note? ☐ Yes ☐ No

If **yes**, when? _____

g. In the last 60 months, did you, your spouse, or someone on your behalf purchase or change an annuity? ☐ Yes ☐ No

If **yes**, when? _____

2. Have you, your spouse, or someone acting on your behalf given a deposit to any health care or residential facility, such as a nursing home, assisted living facility, continuing care retirement community or life care community? ☐ Yes ☐ No

If yes, send copy of agreement.

G. Tax Returns

Did you and/or your spouse file U.S. income tax returns in the last four years? ☐ Yes ☐ No

If yes, send complete copies of these returns including all schedules and attachments.

H. Important Information

Liens on Real Property

Upon receipt of Medicaid, a lien may be filed and a recovery may be made against your real property under certain circumstances if you are in a medical institution and not expected to return home. Medicaid paid on your behalf may be recovered from persons who had legal responsibility for your support at the time medical services were obtained. Medicaid may also recover the cost of services and premiums incorrectly paid.

Transfer of Assets

Federal and State laws provide that an individual may be found ineligible for nursing facility services for a period of time if an individual or an individual's spouse transfers an asset for less than fair market value within the look-back period. The look-back period is the 60 months immediately prior to the date an individual is both institutionalized and has applied for Medicaid.

Annuities

As a condition of Medicaid coverage for nursing facility services, applicants are required to disclose a description of any interest the individual or the individual's spouse has in an annuity. This disclosure is required regardless of whether the annuity is irrevocable or a countable resource.

In addition to the purchase of an annuity, certain transactions made to an annuity by the applicant or the applicant's spouse within the look-back period, may be treated as a transfer unless:

- The State is named the remainder beneficiary in the first position for at least the amount of Medicaid paid on behalf of the annuitant; or
- The State is named in the second position after a community spouse or minor or disabled child, or in the first position if such spouse or representative of such child disposes of any such remainder for less than fair market value.

If documentation is not submitted verifying that the State has been named remainder beneficiary, you may be ineligible for coverage of nursing facility services.

If the annuity is a countable resource at the time of application, you/your spouse are not required to name the State as remainder beneficiary.

I. Certification and Authorization

I certify under penalty of perjury, that the information on this form is correct and complete to the best of my knowledge. I understand that I must report any changes in this information within 10 days of the change.

If eligibility depends on the amount of my and my spouse's resources, by signing this application we authorize verification of our resources with financial institutions for the purpose of determining eligibility. Both spouses must sign below. This authorization will end if my application for Medicaid is denied, or I am no longer eligible for Medicaid, or I/we revoke this authorization in a written statement to my local Department of Social Services.

X _____ X _____

SIGNATURE OF APPLICANT/REPRESENTATIVE — DATE SIGNED

X _____ X _____

SIGNATURE OF APPLICANT'S SPOUSE — DATE SIGNED

Access NY Supplement A

This Supplement must be completed if anyone who is applying is:

- Age 65 or older
- Certified blind or certified disabled (of any age)
- Not certified disabled but chronically ill
- Institutionalized and applying for coverage of nursing home care.
  This includes care in a hospital that is equivalent to nursing home care

Note: If you are applying for the Medicare Savings Program (MSP) only, this Supplement does not need to be completed.

INSTRUCTIONS:

- Sections A through F must be completed and this Supplement must be signed.
- If you or anyone in your household is applying for coverage of nursing home care, you must also complete sections G through I.

A. This Supplement is being completed for:

Legal Last Name	Legal First Name	MI	Social Security Number	Marital Status

Note: The remaining questions are for the person(s) named above.

B. Blind, Disabled or Chronically Ill

1. Are you chronically ill? ☐ Yes ☐ No
   (Examples of chronically ill would be unable to work for at least 12 months because of an illness or injury, or having an illness or disabling impairment that has lasted or is expected to last for 12 months.)

2. Are you Certified Blind by the Commission for the Blind and Visually Handicapped? ☐ Yes ☐ No
   (If yes, send proof.)

3. If you are disabled and working, are you interested in applying for the MBI-WPD program? ☐ Yes ☐ No
   The Medicaid Buy-In program for Working People with Disabilities (MBI-WPD) offers Medicaid coverage to people who are disabled, working, and at least 16 years old but not yet 65 years old. The program allows higher income levels than the regular Medicaid program so working people with disabilities can earn more and keep their Medicaid coverage.

C. Are you living in an adult home or assisted living facility? ☐ Yes ☐ No

D. Resources/Assets (check the box that applies):

☐ You are applying for Medicaid coverage but not coverage of community-based long-term care services. You may attest to the amount of your resources. You are not required to submit documentation of your resources. This coverage does not include nursing home care, home care or any of the community-based long-term care services listed below.*

☐ You are applying for coverage of community-based long-term care services. You must submit documentation of the current amount of your resources.* These services include:

- Adult day health care
- Limited licensed home care
- Private duty nursing
- Hospice in the community
- Hospice residence program
- Assisted living program
- Consumer directed personal assistance program
- Certified Home Health Agency services
- Residential treatment facility care
- Personal emergency response services
- Personal care services
- Managed long-term care in the community
- Waiver and other services provided through a home and community-based waiver program

Note: Some examples of home and community-based programs that provide waivers and other services are Traumatic Brain Injury Program and Long Term Home Health Care Program.

☐ You are institutionalized and applying for coverage of nursing home care. You must submit documentation of your resources back to February 1, 2006, or the past 60 months, whichever is less.

* You may be eligible for short-term rehabilitation services. Short-term rehabilitation services include one commencement/admission in a 12-month period of up to 29 consecutive days of nursing home care and/or certified home health care.

List all resources owned by you and/or your spouse/parent(s), including custodial accounts. **If applying for coverage of nursing home care,** also list any accounts closed since February 1, 2006, or in the past 60 months, whichever period is shorter; include balance at closing and provide an explanation of where the balance was transferred to or how it was spent. On a separate sheet of paper, provide an explanation of each transaction of $2,000 or more. **Note:** Medicaid retains the right to review all transactions made during the transfer look-back period.

1. Checking/Savings/Credit Union Accounts/Certificates of Deposits (CDs):

Bank Name and Account Number	Name of Owner(s)	Current Dollar Amount	Closed Account Balance/ Date Closed
		$	$
		$	$
		$	$
		$	$
		$	$

2. Retirement Accounts (Deferred Compensation, IRA and/or Keogh):

Account Number	Name of Owner(s)	Type/Institution	Current Dollar Amount	Pay Out
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No

3. Life Insurance Policies:

Insurance Company	Policy Number	Name of Owner(s)	Cash Value	Face Value
			$	$
			$	$
			$	$
			$	$
			$	$

4. Annuities, Stocks, Bonds, Mutual Funds:

Name of Owner(s)	Company	Date Purchased	Value
			$
			$
			$
			$
			$
			$
			$

5. Trust Accounts: If you and/or your spouse created or are the beneficiary of a trust, submit a copy of the trust, including the schedule of trust assets.

Name of Trust	Grantor	Trustee(s)	Assets	Beneficiary	Income
			$		$
			$		$
			$		$

6. Burial Assets/Burial Contracts: (Include copies)

Do you and/or your spouse have a pre-paid funeral agreement for you or anyone else in your family? ☐ Yes ☐ No

Do you and/or your spouse have a burial space or plot for you or anyone else in your family? ☐ Yes ☐ No

Do you and/or your spouse have money in a bank account set aside for a burial fund? ☐ Yes ☐ No

If **yes**, in what account(s) is your and/or your spouse's burial fund?

Bank Name and Account Number	Name of Owner(s)	Value
		$
		$
		$

Do you have life insurance to be used as your burial fund? ☐ Yes ☐ No

If **yes**, what is your policy number(s)? _____

If **yes**, is the full cash value to be used for your burial expenses? ☐ Yes ☐ No

Does your spouse have life insurance to be used as a burial fund? ☐ Yes ☐ No

If **yes**, what is the policy number(s)? _____

If **yes**, is the full cash value to be used for burial expenses? ☐ Yes ☐ No

7. Vehicle(s): List all cars, trucks and vans. List all recreational vehicles, including campers, snowmobiles, boats and motorcycles.

Name of Owner(s)	Year/Make/Model	Fair-Market Value	Amount Owed	In Use?
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No

8. Equity Value in Home:

If you own your home, what is the equity value in your home? $ _____

Note: Equity value is the fair market value less any outstanding liens, mortgages, etc.

9. List Any Other Resources:

Resource Type	Name of Owner(s)	Value
		$
		$
		$
		$
		$
		$

E. Real Property (other than your home)

Do you and/or your spouse own or have a legal interest in any other real property? (Check any that apply) ☐ Yes ☐ No

☐ Rental Property	☐ Vacation Property	☐ Time Share	☐ Vacant Land	☐ Other Property Rights (In or outside of New York State)

If **yes,** please answer the following questions:

Name and Address of Owner(s)	Address of Property	Type of Ownership (Check one)	Equity value
		☐ Individual ☐ Joint tenancy ☐ Life estate	$
		☐ Individual ☐ Joint tenancy ☐ Life estate	$
		☐ Individual ☐ Joint tenancy ☐ Life estate	$
		☐ Individual ☐ Joint tenancy ☐ Life estate	$

F. Homestead

1. Do you and/or your spouse own or have a legal interest in your home, including a life estate? ☐ Yes ☐ No
2. If you are in a medical facility and own your home, do you intend to return to your home? ☐ Yes ☐ No
3. If **no,** is anyone living in the home? ☐ Yes ☐ No

   Who is living in the home? _____

   How is this person related to you and/or your spouse? _____

   If you and/or your spouse's child (of any age) is living in the home, is the child disabled? ☐ Yes ☐ No

Note: If there is a legal impediment that prevents you from selling this property, the property is not counted in determining Medicaid eligibility.

STOP HERE unless you or anyone in your household is institutionalized and applying for coverage of nursing home care. However, the last page of this document MUST be signed.

For New York City Residents

G. Applicant Living in a Long-Term Care Facility/Nursing Home

Name of Facility	Date Admitted / /	Telephone Number ( )	
Street Address	City	State	Zip
Applicant's Previous Address	City	State	Zip

H. Asset Transfers

1. Transfers

a. Did you, your spouse, or someone on your behalf transfer, change ownership in, give away, or sell any assets, including your home or other real property? ☐ Yes ☐ No

b. Are you in the process of selling property? ☐ Yes ☐ No

c. Did you, your spouse or someone on your behalf, change the deed or the ownership of any real property, including creating a life estate? ☐ Yes ☐ No
If **yes,** when? _____

d. If you purchased a life estate in another person's home, did you live in the home for at least one year after you purchased the life estate? ☐ Yes ☐ No

e. Did you, your spouse, or someone on your behalf purchase a mortgage, loan, or promissory note? ☐ Yes ☐ No
If **yes,** when? _____

f. Did you, your spouse, or someone on your behalf purchase or change an annuity? ☐ Yes ☐ No
If **yes,** when? _____

2. In the last 60 months, have you or your spouse created or transferred any assets into or out of a trust? ☐ Yes ☐ No

If you answered yes to any of the questions above, explain the transfer(s) below. Attach additional sheets of paper, if needed.

Description of Asset (including income)	Date of Transfer	Transferred to Whom	Amount of Transfer
			$
			$
			$
			$

3. Have you, your spouse, or someone acting on your behalf given a deposit to any health care or residential facility, such as a nursing home, assisted living facility, continuing care retirement community or life care community? **If yes, send copy of agreement.** ☐ Yes ☐ No

I. Tax Returns

Did you and/or your spouse file U.S. income tax returns in the last four years? ☐ Yes ☐ No
If yes, send copies of these returns.

For New York City Residents

Upon receipt of Medicaid, a lien may be filed and a recovery may be made against your real property under certain circumstances if you are in a medical institution and not expected to return home. Medicaid paid on your behalf may be recovered from persons who had legal responsibility for your support at the time medical services were obtained. Medicaid may also recover the cost of services and premiums incorrectly paid.

Federal and State laws provide that any transfer of assets for less than fair market value made by an individual or an individual's spouse, within the transfer of assets look-back period (or 60 months in the case of trust-related transfers) prior to the first of the month in which the individual is both in receipt of nursing facility services and determined otherwise eligible for Medicaid coverage of nursing facility services, may cause the individual to be ineligible for nursing facility services for a period of time.

As a condition of Medicaid coverage for nursing facility services, applicants are required to disclose a description of any interest the individual or the individual's spouse has in an annuity. This disclosure is required regardless of whether the annuity is irrevocable or a countable resource.

In addition to the purchase of an annuity, certain transactions made to an annuity by the applicant or the applicant's spouse on or after February 8, 2006, may be treated as a transfer unless:

- The State is named the remainder beneficiary in the first position for at least the amount of Medicaid paid on behalf of the annuitant; or
- The State is named in the second position after a community spouse or minor or disabled child, or in the first position if such spouse or representative of such child disposes of any such remainder for less than fair market value.

If documentation is not submitted verifying that the State has been named remainder beneficiary, you may be ineligible for coverage of nursing facility services.

If the annuity is a countable resource at the time of application, you/your spouse are not required to name the State as remainder beneficiary.

I certify under penalty of perjury, that the information on this form is correct and complete to the best of my knowledge. I understand that I must report any changes in this information within 10 days of the change.

X _____ X _____

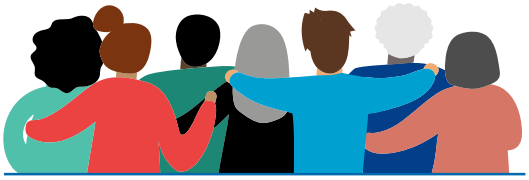
SIGNATURE OF APPLICANT/REPRESENTATIVE DATE SIGNED

X _____ X _____

SIGNATURE OF APPLICANT'S SPOUSE DATE SIGNED

Senior Law Day

Sponsorship Form



SENIOR LAW DAY COLLABORATIVE

2020 Sponsorship Options

ADVERTISING SPONSORSHIP.....$1,500

- *Priority Listing in all print and digital advertisements (listed first and in bold in White Plains Program and any other alphabetical listing of sponsors); preferential placement on Sponsor logo page*
- *Logo/Name recognition at events and on website, with hyperlink to sponsor's website*
- *Distribution of your organization's own printed advertising materials at the event on our shared information tables*

COMMITTEE MEMBER SPONSORSHIP.....$1,000

- *Listing in all print and digital advertisements · Logo/Name recognition at event, on website and in White Plains Program*
- *Distribution of your organization's own printed advertising materials at the event on our shared information tables*

FRIENDS OF SENIOR LAW DAY.....$350

Individual Name Listing in the printed Programs, website and advertisements under "Friends" section

Name of Sponsor _____
Contact Name (if different from above) _____
Business/Organization Name _____
Address _____
Phone _____
Email _____
Amount Authorized: $_____
_____**Enclosed is a check made payable to: Westchester Public/Private Partnership for Aging Services or**
_____**Please Charge $**_____**to my:** _____ **Visa** _____ **MasterCard**
Card No. _____
Exp. Date _____ **CVC Code:** _____
Print name as it appears on card _____
Signature _____

Please submit this registration form by mail or email.

Ms. Charlotte Nottingham, c/o DSPS 10th Fl., 9 South First Avenue, Mount Vernon, New York 10550
Phone: (914) 813-6407 **Email:** cmn9@westchestergov.com

Senior Law Day programming is under the 501(c)(3) status of Westchester Public/Private Membership Fund for Aging Services Inc. (Tax ID #:13-3631718).

We provide free educational programs and consultations for Westchester seniors and their families. Without your support, Senior Law Day programs would not be possible!

Visit www. Seniorlawday.info for more information and resources